

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030585

FILED VS SEP 11 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7897** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 wks.	c. CITY OR TOWN University City
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1114 Midland
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ETTA Middle LIPSCHITZ Last	4. DATE OF DEATH Month Au Day g. 24 Year 1959
---------------------------------------------------------------------------------------	-----------------------------------------------------------------------

5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------	-------------------------------------	--------------------------------------------	------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lithuania	12. CITIZEN OF WHAT COUNTRY USA
-----------------------------------------------------------------------------------------------------------------	-----------------------------------	----------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME Bernard Bricker	13b. MOTHER'S MAIDEN NAME unk.	14. NAME OF HUSBAND OR WIFE Harry M. Lipschitz
----------------------------------------------	------------------------------------------	----------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Harry M. Lipschitz 1114 Midland
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	---------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Anemia	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ASHO	5 yrs
	DUE TO (c) D.A. Beta Mellitur	10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260X	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
---------------------------------------------------	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	------------------------------	--------	-------

21. I attended the deceased from **1955** to **8/24/59** and last saw her ^{him} alive on **8/24/59**
Death occurred at **10 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Miriam E. Revin	22b. ADDRESS 100 n. Euclid.	22c. DATE SIGNED 8/25/59
------------------------------------------------------------	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 8/26/59	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol	23d. LOCATION (City, town, or county) Laurel, Mo.	(State)
-------------------------------------------	-----------------------------	---------------------------------------------------------------------	-------------------------------------------------------------	---------

24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson	ADDRESS	25. DATE RECD. BY LOCAL REG. MS 2659	26. REGISTRAR'S SIGNATURE Good Smith, M.D.
---------------------------------------------------------------	---------	------------------------------------------------	------------------------------------------------------

CR

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Lawrence J. Dennis

Licensed Embalmer No. 3988

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.