

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030792

FILED VS AUG 18 1959

Primary Registration District No. \_\_\_\_\_

Registrar's No. **2 7339**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>		Length of stay in 1b <b>9 DAYS</b>		c. CITY OR TOWN <b>ST LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS ADMIN HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5943 PERSHING</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JULIUS</b> Middle <b>V.</b> Last <b>SILBERBERG</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/11/92</b>	9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>CINCINNATI, OHIO</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>WILLIAM SILBERBERG</b>			13b. MOTHER'S MAIDEN NAME <b>AGUSTA KUEHLING</b>		14. NAME OF HUSBAND OR WIFE <b>MARY SILBERBERG</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>VA 459-01-1527</b>		17. INFORMANT Address <b>VA HOSP RECORDS 915 N GRAND ST LOUIS, MO.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, RTIGHT WITH MASSIVE METASTASIS</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) -		-		-	
		DUE TO (c) -		-		-	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) -					PART III. If deceased was female was there a pregnancy in last 90 days. - <b>1621</b> - <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <b>VA 7/27/59</b>		20f. CITY, TOWN, OR LOCATION <b>8/5/59</b>		COUNTY STATE	
21. I attended the deceased from <b>VA</b> , to <b>8/5/59</b> and last saw him alive on <b>8/5/59</b> Death occurred at <b>9:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Robert M. Stroud</b>			22b. ADDRESS <b>VAH, ST LOUIS, MO.</b>		22c. DATE SIGNED <b>8/6/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-10-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>			
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>			ADDRESS <b>3840 Lindell Blvd</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 7 '59</b>	26. REGISTRAR'S SIGNATURE <b>Neal Smith, M.D.</b>	

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 Francis Willie

Licensed Embalmer No. 356

P. O. Address 3840

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.