URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59-033934

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7947

ENDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Jewish Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: St.Louis

c. CITY OR TOWN: University City — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 7355 Stanford Ave. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ALLEN — Middle — Last JAFFIE

4. DATE OF DEATH: Month AUGUST — Day 26th, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: Unknown

9. AGE (last birthday): Abt.43 — 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): Credit-Manager

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Nathan Jaffie

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Lillian Jaffie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W.W.#2

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Mrs.Lillian Jaffie — Address: 7355 Stanford

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary infarction

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c): 465X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerotic Heart Disease

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 April, 1958, to present and last saw him alive on Aug 26, 1959

Death occurred at 8:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Michael M. Karl, MD

22b. ADDRESS: 4652 Maryland, St.Louis,Mo.

22c. DATE SIGNED: 8-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 8/26/59

23c. NAME OF CEMETERY ~~OR CREMATORY~~: Beth Hamedrosh Hagedol

23d. LOCATION (City, town, or county) (State): St.Louis County Missouri

24. FUNERAL DIRECTOR — ADDRESS: Herman Rindskopf Inc.5216 Delmar

25. DATE RECD. BY LOCAL REG.: AUG 27 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed John Kettles

Licensed Embalmer No. 3880

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.