

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 29 1959

59-033955

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **8605**

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 35 yrs.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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) 5421 Wabada Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL (AKA SAM) KAPLAN			4. DATE OF DEATH Month Day Year Sept. 17, 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1898	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail Dry Gds.	11. BIRTHPLACE (City and state or country) Russia	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Paul Kaplan		13b. MOTHER'S MAIDEN NAME Fay (unk)		14. NAME OF HUSBAND OR WIFE -	
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. Unk.	17. INFORMANT Address Gertrude Kaplan 5421 Wabada		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction		INTERVAL BETWEEN ONSET AND DEATH 48 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) auricular fibrillation		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) * Parkinson's Disease		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 **1954** to **1959** and last saw him alive on **Sept 17 1959** at **9 am**
Death occurred at **10:25 am 9/16/59** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Shaved Freedman M.D.		22b. ADDRESS 607 No. Grand Blvd		22c. DATE SIGNED 9/17/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 9/18/59	23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha	23d. LOCATION (City, town, or county) University City, Mo.	

24. FUNERAL DIRECTOR ADDRESS Berger MEMORIAL 4715 McPherson		25. DATE RECD. BY LOCAL REG. SEP 18 59	26. REGISTRAR'S SIGNATURE Roal Smith, M.D. <i>mrg</i>
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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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Lawrence J. DeL...*

Licensed Embalmer No. 3988

P. O. Address _____

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