URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-034084

FILED VS SEP 16 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7830 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in Ib: 5days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 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): 8147 Delcrest — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First HERBERT Middle A. Last MAZUR
4. DATE OF DEATH: Month Aug. Day 23, Year 1959
5. SEX: male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-25-1919
9. AGE (last birthday): 40 — 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): Pediatrician
10b. KIND OF BUSINESS OR INDUSTRY: Doctor of Medicine
11. BIRTHPLACE (City and state or country): Tampa, Florida
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Rabbi Jacob R. Mazur
13b. MOTHER'S MAIDEN NAME: Edith Frankel
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Dr. Saul Silvermintz Address: 20 Granada, Ladue Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adrenal insufficiency
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Adrenal tumor — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
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. ☐ 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 Aug 20, 1959, to Aug 23 1959 and last saw her/him alive on Aug. 23, 1959
Death occurred at 12:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Morris Abramson (Degree or title) M.D.
22b. ADDRESS: 4401 W. Pine St. Louis 8
22c. DATE SIGNED: Aug 24/59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 8-24-59
23c. NAME OF CEMETERY OR CREMATORY: Chesed Shel Emeth
23d. LOCATION (City, town, or county) (State): University City, Mo.
24. FUNERAL DIRECTOR: Berger Memorial ADDRESS: 4715 McPherson
25. DATE RECD. BY LOCAL REG.: AUG 24 59
26. REGISTRAR'S SIGNATURE: Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3988

P. O Address_____

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