

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034141

FILED VS. OCT. 8 1959

2 8899

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ST LOUIS CITY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If outside, give location) 1438 East Grand	

3. NAME OF DECEASED (Type or print) REBECCA First NEWMAN Last	4. DATE OF DEATH Sept. 26, 1959 Month Day Year
--	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (last birthday) Abt. 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
-------------------------	----------------------------------	---	------------------------------------	--	---	-----------------

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

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	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. no	17. INFORMANT Address J. Fishman-7417 Byron Place
---	--------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
DUE TO (b) FRACTURED HIP		3RD PO DAY
DUE TO (c) STRANGULATED HERNIA		12TH PO DAY

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. <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 checked="" 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.) Tell from stretcher at Jewish Hosp.
20c. TIME OF INJURY Hour ? a.m. ? p.m. 9-19-59 Month, Day, Year		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Jewish Hospital	20f. CITY, TOWN, OR LOCATION St. Louis	COUNTY Mo.	STATE
21. I attended the deceased from 9/14/59 to 9/26/59 and last saw him alive on 9/26/59		Death occurred at 1:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Ralph J. Graff MD	22b. ADDRESS 7132 Washington	22c. DATE SIGNED 9/27/59
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/28/59	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.	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. SEP 28 59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
---	--	--

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

John Ketter
Licensed Embalmer No. 3880

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.