

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 27 1959

59-037345

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 402

RENDERED

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY City of St. Louis									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Farmington-St. Francois Twp.		Length of stay in lb 24Y; 5M; 13DAYS		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #4			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1388 Montclair		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Abraham Middle Fischman (Fischmann) Last _____				4. DATE OF DEATH Month October Day 17 Year 1959									
5. SEX Male		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 1/1/1887		9. AGE (last birthday) 72		IF UNDER 1 YEAR Months 9 Days 16 Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser				10b. KIND OF BUSINESS OR INDUSTRY Garment Industry		11. BIRTHPLACE (City and state or country) Russia		12. CITIZEN OF WHAT COUNTRY Russia					
13a. FATHER'S NAME Sam Fischman				13b. MOTHER'S MAIDEN NAME Rita Berg				14. NAME OF HUSBAND OR WIFE Dora					
15. WAS DECEASED IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT & Records State Hospital No. 4 Louis Fischman 7524 Cromwell								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis - - - - - instantaneous.										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) Dementia Praecox Psychosis - - - - - about 30 yrs.								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					
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 April 29, 1935 to October 17, 1959 xxx last saw him alive on Oct. 17, 1959 Death occurred at 2:15 A. M. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Esther Rudloff</i> (Degree or title)				22b. ADDRESS State Hospital No. 4 Farmington, Missouri				22c. DATE SIGNED 10-20-59					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/19/1959		23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha		23d. LOCATION (City, town, or county) University City, Mo							
24. FUNERAL DIRECTOR Berger Funeral Home, St. Louis, Missouri				25. DATE RECD. BY LOCAL REG. Oct. 20, 1959		26. REGISTRAR'S SIGNATURE <i>Esther Rudloff</i>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS OCT 27 1959

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 _____

Licensed Embalmer No. 040

P. O. Address Farming

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.