

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037749

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8823**

1. PLACE OF DEATH a. COUNTY ST LOUIS CITY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY ST LOUIS							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		Length of stay in 1b 2 wks.		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 HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 9281 OLD BONHOMME		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MAX Middle _____ Last JOSEPH				4. DATE OF DEATH Month SEPT. Day 24 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 Unk. about 78	9. AGE (last, birthday) 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) Painter			10b. KIND OF BUSINESS OR INDUSTRY Decorating		11. BIRTHPLACE (City and state or country) RUSSIA		12. CITIZEN OF WHAT COUNTRY USA				
13a. FATHER'S NAME Selig Joseph			13b. MOTHER'S MAIDEN NAME Unk.			14. NAME OF HUSBAND OR WIFE BESSIE					
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 Mrs. Cecelia Larkins Address 9281 Old Bonhomme						
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 EMBOLISM							INTERVAL BETWEEN ONSET AND DEATH Sudden				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) 2 wks Post ABOVE-KNEE AMPUTATION		DUE TO (c) 450.0							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease given in PART I (a) GENERALIZED ARTERIOSCLEROSIS						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 9/7/59 4:25 a.m. to 9/24/59 and last saw her/him alive on 24 SEPT. 1959 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Ralph J. Gruff MD				22b. ADDRESS 7132 Washington				22c. DATE SIGNED 9/24/59			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Rem.		23b. DATE 9/25/59		23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth				23d. LOCATION (City, town, or county) University City, Mo.			
24. FUNERAL DIRECTOR Berger emorial 4715 McPherson				25. DATE RECD. BY LOCAL REG. SEP 25 '59		26. REGISTRAR'S SIGNATURE Loal 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James A. Anderson*
Licensed Embalmer No. 4229

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.