

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038101

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **9137**

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, MISSOURI		Length of stay in 1b 50 yrs.		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 BARNES HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6220 Northwood		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NATHAN Middle SORKIN Last				4. DATE OF DEATH Month OCTOBER Day 5 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-1898	9. AGE (last birthday) 61	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) Cabinet Maker			10b. KIND OF BUSINESS OR INDUSTRY Fixture Manf.		11. BIRTHPLACE (City and state or country) Russia		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Isadore Sorkin			13b. MOTHER'S MAIDEN NAME Unk.			14. NAME OF HUSBAND OR WIFE Pearl		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW#1			16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Pearl Sorkin 6220 Northwood			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION							INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE							1 YEAR	
DUE TO (c) 420.0								
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 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 AUGUST 1959 to OCT. 5, 1959 and last saw her OCT. 5, 1959 Death occurred at 4:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Harold J. Smith, M.D.</i>				22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 10/5/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 10/6/59	23c. NAME OF CEMETERY OR CREMATORY Cheyra Kadisha		23d. LOCATION (City, town, or county) University City, Mo.			(State)	
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson			25. DATE RECD. BY LOCAL REG. OCT 5 '59		26. REGISTRAR'S SIGNATURE <i>Harold Smith, M.D.</i> mjc			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

82 8701-1

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 J. Deine*

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.