

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038208

FILED VS OCT 19 1959

2 9136

STATE FILE NUMBER

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

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		Length of stay in 1b 50 yrs.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED IN HOSPITAL OR INSTITUTION Hebrew Methodist Old Folks Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1023 Hamilton Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) BEN (AKA BENJAMIN) WEXLER	First Middle Last	4. DATE OF DEATH Oct. 2, 1959	Month Day Year
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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 5/1/86	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator	10b. KIND OF BUSINESS OR INDUSTRY Laundry	11. BIRTHPLACE (City and state or country) Russia	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Mendel Wexler	13b. MOTHER'S MAIDEN NAME Toba (unk)	14. NAME OF HUSBAND OR WIFE Bertha
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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. 492-32-0251	17. INFORMANT Mrs. Shirley Roodman 1343 Coolidge	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	1/2 hour.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	Yrs.
	Coronary Arteriosclerosis-Angina	
	DUE TO (c)	Yrs.
	Generalized Arteriosclerosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Parkinson's Disease	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
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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.)
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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
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21. I attended the deceased from **6/59** to **10/2/59** and last saw him alive on **10/1/59**
Death occurred at **11:15 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ray Spertman M.D. (Degree or title)	22b. ADDRESS 4652 Maryland	22c. DATE SIGNED 10/2/59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10/5/59	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	23d. LOCATION (City, town, or county) (State) University City, Mo.
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24. FUNERAL DIRECTOR Berger Memorial 4715 1/2 c^r herson ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 5 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m & b.

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 Quirio G. Gaudin
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.