

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-041567

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9772** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				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 12 days		c. CITY OR TOWN University City		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) 930 Eastgate		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAM Middle _____ Last BLUESTEIN				4. DATE OF DEATH Month 10 Day 24 Year 59			
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 ab. 1888	9. AGE (last birthday) ab. 71	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done or of working if retired) Retired Presser		10b. KIND OF BUSINESS OR INDUSTRY Garment Mfg.		11. BIRTHPLACE (City and state or country) USSR		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Meyer Bluestein			13b. MOTHER'S MAIDEN NAME Tama (unk)		14. NAME OF HUSBAND OR WIFE Sarah		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, No (unknown)) (If yes, give major dates of service) No		16. SOCIAL SECURITY NO. 488-09-9078AB		17. INFORMANT Address Mrs. Sarah Bluestein 930 Eastgate			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular collapse DUE TO (b) Etiology of shock undetermined DUE TO (c) 610x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 8 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3 days post-operative sympberbic prostatectomy					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 10-14-59 to 10-24-59 and last saw her him alive on 10-24-59 Death occurred at 3:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Clarence M. Benage M.D.			22b. ADDRESS 9123 Wrenwood Lane			22c. DATE SIGNED 10/25/59 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 10-26-59	23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha Cem.		23d. LOCATION (City, town, or county) Univ. City, Mo.			
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson			25. DATE RECD. BY LOCAL REG. OCT 26 1959		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 *Oliver A. Gudberg*
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.