

MINNESOTA DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 30 1959

59-041873

210799

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 <b>Missouri</b> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>275 Union</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>J.</b> Last <b>GLASS</b>			4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/3/76</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Romania</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Helen Glass</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT Address <b>Mrs. Helen Glass-275 Union</b>			

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 <b>5 Hours.</b>
IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arterial hypertension.</b>	<b>5.8 years</b>	
	DUE TO (c) <b>Arteriosclerosis, generalized</b>	<b>10 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>33 IX</b>			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
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21. I attended the deceased from **9 45 p** **19 7 4** to **Nov 22 1959** and last saw <sup>her</sup> <sub>him</sub> live on **11/22/59**  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Flora Freedman M.D.</b>	22b. ADDRESS <b>607 No. Grand Blvd</b>	22c. DATE SIGNED <b>11/23/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/23/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>	23d. LOCATION (City, town, or county) <b>Chicago, Illinois</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Herman Rindskopf, Inc. 5216 Delmar</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 23 1959</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

X

X

X

**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 Arthur B. Duboulet

Licensed Embalmer No. 3691

P. O. Address St Louis

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.