

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 3 0 1959

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211410

STATE FILE NUMBER

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

NDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri				Length of stay in 1b		c. CITY OR TOWN University City - 32	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1436 SHERIDAN DRIVE	
3. NAME OF DECEASED (Type or print) First Barry Middle Doy Last Koslow				4. DATE OF DEATH Month 11 Day -27 Year -59			
5. SEX MALE		6. COLOR OR RACE W		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-26-59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME RALPH Koslow				13b. MOTHER'S MAIDEN NAME ELEANOR R. PLATKE		14. NAME OF HUSBAND OR WIFE	
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. NONE		17. INFORMANT RALPH Koslow, 1436 SHERIDAN, U. City - 32	
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) Respiratory failure							
DUE TO (b) Prematurity							
DUE TO (c) 773.5							
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 checked="" type="checkbox"/> NO <input 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 11-26-59 to 11-27-59 and last saw her alive on 11-27-59 Death occurred at 8:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE B. H. Cohen (Degree or title) M.D.				22b. ADDRESS 138 W. Meramec Ave Clayton Mo			22c. DATE SIGNED 11-27-59
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-31-59		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Rowland Mortuary Svc. 4104-06 Manchester				25. DATE RECD. BY LOCAL REG. DEC 9 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 _____

Licensed Embalmer No. _____

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.