

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003110

FILED VS FEB 1 0 1960

2 1123

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 <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>47 yrs.</u>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Y <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR JEWISH OR CHODOX INSTITUTION <u>Old Folks Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1438 E. Grand</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle _____ Last <u>ASTRACHAN</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>1,</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/20/76</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>USSR</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unk.</u>		13b. MOTHER'S MAIDEN NAME <u>Unk.</u>		14. NAME OF HUSBAND OR WIFE <u>Beckie</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Sam Zibit 1438 E. Grand</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident - Left Hemiplegia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</u>	
DUE TO (b) <u>Arteriosclerosis, Generalized</u>					<u>Yrs.</u>	
DUE TO (c) <u>331x</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic H. Dis. & Heart Block.</u>					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 <u>10/54</u> to <u>2/1/60</u> and last saw ^{her} him alive on <u>1/28/60</u> Death occurred at <u>7:50 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Roy Greenbaum MD</u> (Degree or title)			22b. ADDRESS <u>4652 Maryland.</u>		22c. DATE SIGNED <u>2/1/60.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u>	23b. DATE <u>2/2/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chevra Kadisha</u>		23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Berger Memorial 4715 McPherson Avenue</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 1 1960</u>	26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>			

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 *Quis J. Guderg*

Licensed Embalmer No. 4339

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.