

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003293

FILED VS. FEB. 1 1960

2 383

STATE FILE NUMBER

INDEXED

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		Length of stay in 1b Over 5 years	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 St. Louis State		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6809a Washington Ave.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Leon Davidson	First Middle Last	4. DATE OF DEATH January 11, 1960	Month Day Year
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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 4/18/77	9. AGE (last birthday) 82	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) Clerk	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Fort Worth, Texas	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Wolf Davidson	13b. MOTHER'S MAIDEN NAME Sophie Schwartz	14. NAME OF HUSBAND OR WIFE Robert Florence
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No unknown) (If yes, give war or dates of service) Unk.	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Mrs. Leon Davidson-602 Westgate	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)		
Coronary thrombosis		
Lobar pneumonia		
Arteriosclerotic heart disease		
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 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
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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 Oct. 1, 1954 to Jan. 11, 1960 and last saw her alive on Jan. 11, 1960	Death occurred at 3:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Joseph Pasquardo, M.D. (Degree or title)	22b. ADDRESS 5400 Arsenal St.	22c. DATE SIGNED 1/11/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/13/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Herman Rindskopf, Inc. 5216 Delmar	25. DATE RECD. BY LOCAL REG. JAN 12 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. E.P.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

