

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004160

FILED VS. FEB. 1 1960

Primary Registration District No.

Registrar No.

261

STATE FILE NUMBER

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 <b>St. Louis</b>				Length of stay in lb		c. CITY OR TOWN <b>Richmond Hgts.</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1001 Surrey Hills Dr.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle Last <b>Tober</b>				4. DATE OF DEATH Month <b>January</b> Day <b>8th</b> Year <b>1960</b>			
5. SEX <b>Female</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	
9. AGE (last birthday) <b>Abt. 74</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13a. FATHER'S NAME <b>WILLIAM SAIFER</b>		13b. MOTHER'S MAIDEN NAME <b>UNK.</b>	
14. NAME OF HUSBAND OR WIFE <b>Abraham E.M. Tober</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>Abraham E.M. Tober 1001 Surrey Hills</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of Breast</b> DUE TO (c) <b>170 x</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma of Colon - 15 years resected</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b>May 13, 1959</b> to <b>January 8, 1960</b> and last saw her <b>live</b> on <b>Jan 8, 1960</b> Death occurred at <b>10A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deplete or title) <b>Levellin Sale, M.D.</b>				22b. ADDRESS <b>100 N. Euclid</b>		22c. DATE SIGNED <b>1/8/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1/10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B' Nai Amoona Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Herman Rindskopf Inc. 5216 Delmar</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 8 1960</b>		26. REGISTRAR'S SIGNATURE <b>Neal Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

**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 Peter B. DeBerone

Licensed Embalmer No. 369

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.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_