

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008649

FILED VS. MAR 14 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's **2-2328** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 wks.	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 Jewish Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7746 How Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ANNA Middle MOSCOWITZ Last	4. DATE OF DEATH Month Feb. Day 27 Year 1960
---	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH unk.	9. AGE (last birthday) ab. 76	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) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) USSR	12. CITIZEN OF WHAT COUNTRY USA
---	-----------------------------------	---	---

13a. FATHER'S NAME Jack Lifshitz	13b. MOTHER'S MAIDEN NAME Gertrude (unk)	14. NAME OF HUSBAND OR WIFE Abraham
--	--	---

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 Sam Marks 7746 How Address
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon with Metastases to lungs DUE TO (b) 153.8 DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

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 checked="" 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 Feb. 2, 1959 to Feb. 27, 1960 and last saw her/him alive on Feb. 22, 1960 Death occurred at 730 P on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Robert Potashnick M.D.	22b. ADDRESS 3720 Washington	22c. DATE SIGNED 2/28/60
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 2/29/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron	23d. LOCATION (City, town, or county) (State) Flushing, Long Island, N.Y.
--	-----------------------------	---	---

24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson ADDRESS	25. DATE RECD. BY LOCAL REG. FEB 29 1960	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 *Quir J. Padura*
Licensed Embalmer No. 4229

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.