

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 23 1960

STATE FILE NUMBER
60-008951

Registration District No. _____ Primary Registration District No. _____ Registrar's **2, 1694**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis		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) 1438 E. Grand Blvd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ABRAHAM Middle TABACHNICK Last				4. DATE OF DEATH Month February Day 11 Year 1960					
5. SEX Male	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 Unknown	9. AGE (last birthday) Abt. 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Scrap Metal		11. BIRTHPLACE (City and state or country) Russia		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Joseph Tabachnick			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Rose Tabachnick			
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. Unknown		17. INFORMANT Address Mrs. Pearl Chazen-7121 Tulane Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 420.1									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Depressive Psychosis.					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 1/9/60 to 2/11/60 and last saw her/him alive on 2/11/60 Death occurred at 6 p.m. 2/11/60 on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Date or title) <i>Samuel M. Smith M.D.</i>				22b. ADDRESS Jewish Hospital				22c. DATE SIGNED 2/12/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2/12/60	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri				
24. FUNERAL DIRECTOR ADDRESS Herman Rindskopf, Inc. 5216 Delmar				25. DATE RECD. BY LOCAL REG. FEB 12 1960		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

22/18/60

Initials

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Initials

Initials

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Initials

February 11, 1950

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Initials

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 _____

John Ketter

Licensed Embalmer No. 3880

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, the also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Initials

Initials

Initials