

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016854

FILED VS APR 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar No. **3 4110** 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 _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 60 yrs	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 Firmin DesLoge Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 1504 S. 14th St. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MINNIE Middle _____ Last GOLD			4. DATE OF DEATH Month April Day 13 Year 1960		
5. SEX Female	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 9-15-1893	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done if not great part of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) USSR	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Ben Forman		13b. MOTHER'S MAIDEN NAME Rose (unk)		14. NAME OF HUSBAND OR WIFE Nathan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No		16. SOCIAL SECURITY NO. 496-35-7173		17. INFORMANT Nathan Gold Address 1504 S. 14th St.	

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) congestive Heart Failure		1955 to 1960
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic Heart Disease	
	DUE TO (c) 420.0	

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 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 **Mar 10, 1960** to **April 13, 60** and last saw her alive on **April 13, 60**
Death occurred at **4-13-60** **11 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Georell Duane M.D.		22b. ADDRESS 950 - Francis Pl.		22c. DATE SIGNED 4-14-60
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 4-15-60	23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha Cem.	23d. LOCATION (City, town, or county) (State) Univ. City, Mo.	
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson ADDRESS		25. DATE RECD. BY LOCAL REG. APR 14 1960	26. REGISTRAR'S SIGNATURE Earl Smith. M.D.	

DOCUMENT

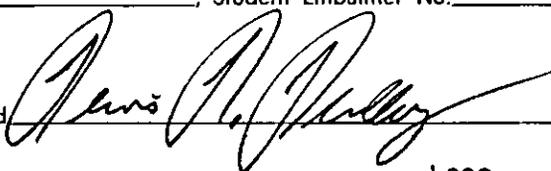
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 4229

P. O. Address _____

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