

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020646

FILED VS MAY 25 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5020** 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 1 Day	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 Alexian Bros, Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3533 So. Jefferson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle Baron Last Baron			4. DATE OF DEATH Month May 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 7/21/71	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Abraham Baron		13b. MOTHER'S MAIDEN NAME Cacelia Jolowicz		14. NAME OF HUSBAND OR WIFE Isabelle Baron	
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 A.R. Baron, Poplar Bluff, Mo. 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) Poplery Cerebral Hypertension & Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 14 hrs 4 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) 334x	
DUE TO (c)		
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.)
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
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21. I attended the deceased from **Dec 1956** to **May 9** and last saw her alive on **May 4-1960**
Death occurred at **1:30 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Arthur J. Helderle M.D.	22b. ADDRESS 506 Olive St St Louis Mo	22c. DATE SIGNED 5/11/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 13, 1960	23c. NAME OF CEMETERY OR CREMATORY Mb. Olive Jewish Cem., St. Louis Co., Mo.	23d. LOCATION (City, town, or county) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR Wacker-Helderle, 3634 Gravois	25. DATE RECD. BY LOCAL REG. MAY 12 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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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 Robert J. Thompson

Licensed Embalmer No. 3497

P. O. Address St. Louis

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