

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 23 1960

318

Primary Registration District No.

1003

Registrar's No.

4734

=60-021559

STATE FILE NUMBER

ENDED

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>              |  | Length of stay in 1b<br><b>4 days</b>   | c. CITY OR TOWN <b>University City</b> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>721 Westgate</b> Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                               |  |   |  |
|--|-------------------------------|--|---|--|
| 3. NAME OF DECEASED<br>(Type or print) <b>LILLIAN SOBOL</b>  |                               |  | 4. DATE OF DEATH <b>May 3, 1960</b>                       |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>Unk.</b>                              | 9. AGE (last birthday) <b>ab. 49</b>         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>          |                               | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and state or country)<br><b>USSR</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>    |
| 13a. FATHER'S NAME<br><b>Sam Hidelman</b>  |                               | 13b. MOTHER'S MAIDEN NAME<br><b>Rose (unk)</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Arthur</b> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |                               | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT Address<br><b>Arthur Sobol 721 Westgate</b> |  |

|  |   |                                  |
|--|---|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |   | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the lung</b>  |   | <b>6 wks</b>                     |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | DUE TO (b) <b>Carcinoma of the breast</b> | <b>4 yrs</b>                     |
|  | DUE TO (c) <b>170X</b>                    |                                  |

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|---|--|---|--|
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|---|--|

|   |   |  |   |
|---|---|--|---|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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 **Dec 1959** to **May 3, 60** and last saw her alive on **May 3, 60**  
Death occurred at **5:40 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                       |                                     |
|---|---------------------------------------|-------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>Barrett L. Tausig M.D.</b> | 22b. ADDRESS<br><b>4500 Olive St.</b> | 22c. DATE SIGNED<br><b>May 4 60</b> |
|---|---------------------------------------|-------------------------------------|

|  |                            |  |   |
|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Rem.</b> | 23b. DATE<br><b>5/6/60</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chesed Shel Emeth</b> | 23d. LOCATION (City, town, or county) (State)<br><b>University City Mo.</b> |
|--|----------------------------|--|---|

|   |   |  |
|---|---|--|
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Berger Memorial 4715 McPherson</b> | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 4 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b> |
|---|---|--|

218B.

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

*NOT Embalmed*  
*James J. DeLuca*

Licensed Embalmer No. 3988

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, he also shall sign in his OWN handwriting.

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