

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 10 1960

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-60-028071

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 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 2 yrs. | c. CITY OR TOWN Olivette | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Med. Center | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 14 Birnawoods | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First BECKIE Middle AXELBAUM Last | | | 4. DATE OF DEATH Month July Day 24 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. 101 | IF UNDER 1 YEAR Months _____ Days _____ |
| 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) Russia | 12. CITIZEN OF WHAT COUNTRY Russia | |
| 13a. FATHER'S NAME Boruch Axelbaum | | 13b. MOTHER'S MAIDEN NAME Unk. | | 14. NAME OF HUSBAND OR WIFE Itzak | |
| 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 Address Louis Axelbaum 14 Birnawoods | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Centrosclerotic Heart Disease | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.0 | | | | | |
| DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Arteriosclerosis | | | | 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 Apr 18, 1958 to Jul 24, 1960 and last saw her alive on 7/16/60 Death occurred at 6:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Morris Axelbaum (Printed or title) | | | 22b. ADDRESS 3720 Worsley Avenue | | 22c. DATE SIGNED 7/25/60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. | 23b. DATE 7/26/60 | 23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth | | 23d. LOCATION (City, town, or county) (State) University City, Mo. | |
| 24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson | | | 25. DATE RECD. BY LOCAL REG. JUL - 25 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M & B

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

Quis G. Gudberg

Licensed Embalmer No. 4729

P. O. Address _____

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.