URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 20 1960

-60-039829

STATE FILE NUMBER

ENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10133

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: JEWISH HOSPITAL — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI COUNTY: ST.LOUIS
c. CITY OR TOWN: UNIVERSITY CITY — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): # 1 DELCREST DR. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First N A T H A N Middle Last H I K E N
4. DATE OF DEATH: Month Day Year OCTOBER 17th, 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4/10/95
9. AGE (last birthday): 65 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (City and state or country): Russia
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Israel Hiken
13b. MOTHER'S MAIDEN NAME: Lena unk
14. NAME OF HUSBAND OR WIFE: SADIE HIKEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): UNK, (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNK.
17. INFORMANT: Address: Mrs.S.Hiken # 1 Delcrest Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.1
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 May, 1955, to October 17, 1960 and last saw ~~her~~ him alive on October 17, 1960
Death occurred at 10:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Julius Elson, M.D.
22b. ADDRESS: 3720 Washington St. Louis
22c. DATE SIGNED: 10/19/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10/20/60
23c. NAME OF CEMETERY OR CREMATORY: Chesed Shel Emeth Cem.
23d. LOCATION (City, town, or county) (State): St.Louis County Missouri

24. FUNERAL DIRECTOR: Herma n Rindskopf Inc. ADDRESS: 5216 Delma r
25. DATE RECD. BY LOCAL REG.: OCT 19 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

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._____

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.