

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b <i>4</i> DAYS	c. CITY OR TOWN <i>Clayton (5)</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Jewish Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>6312 N. Rosebury</i>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>IDA</i> Middle Last <i>GELLMAN</i>			4. DATE OF DEATH Month <i>12</i> Day <i>9</i> Year <i>1960</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 7, 1894</i>	9. AGE (to birthday) <i>66</i>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (City and state or country) <i>USSR</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>Morris Mendel Rosenberg</i>		13b. MOTHER'S MAIDEN NAME <i>Fannie (unk)</i>		14. NAME OF HUSBAND OR WIFE <i>Abe Gellman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Jack Goldberg 27 Stacy Dr. Clayton 32</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Arterio Sclerotic Heart Disease</i>		<i>10 years</i>
	DUE TO (c) <i>420.0</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chol. Cholecystitis</i>		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	
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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.)
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20c. TIME OF INJURY Hour <i>1:00</i> a.m. p.m.	Month, Day, Year
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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 <i>Clayton</i>	COUNTY <i>St. Louis</i>	STATE <i>Mo.</i>
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21. I attended the deceased from *1948* to *12/8/60* and last saw *her* alive on *12/8/60*.
Death occurred at *1:00* a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Jessie M. Kottner MD</i>	(Degree or title)	22b. ADDRESS <i>4409 W Pine</i>	22c. DATE SIGNED <i>12/9/60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>12-9-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Chesed Shel Emeth Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>University City, Mo.</i>
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24. FUNERAL DIRECTOR <i>Berger Memorial 4715 McPherson</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>DEC 9 1960</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith MD</i>
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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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *[Handwritten Signature]*
Licensed Embalmer No. 5988

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.