

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 9 1963 318

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STATE FILE NUMBER 61-3297

AMENDED

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 <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in lb <b>4 days</b>		c. CITY OR TOWN <b>University City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>8214 Montreal</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LEAH</b> Middle _____ Last <b>KLAMEN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>59</b>	9. AGE (last birthday) <b>Aug. 18, 1901</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Roumania</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Max Markovitz</b>			13b. MOTHER'S MAIDEN NAME <b>Rosa Leibowitz</b>			14. NAME OF HUSBAND OR WIFE <b>Charles</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Charles Klamen 8214 Montreal</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b> <b>with generalized metastases</b> DUE TO (b) _____ DUE TO (c) <b>170X</b>							INTERVAL BETWEEN ONSET AND DEATH <b>abt 45yr</b>
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>5/5/44</b> to <b>1/31/61</b> and last saw her alive on <b>1/31/61</b> Death occurred at <b>4:32 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Jeanette Kadish M.D.</b> (Degree or title)				22b. ADDRESS <b>811 N. Taylor Ave St. Louis 8 Mo</b>		22c. DATE SIGNED <b>2/1/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2/1/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chebra Kadisha</b>		23d. LOCATION (City, town, or county) (State) <b>University City, Missouri</b>		
24. FUNERAL DIRECTOR <b>Berger Memorial 4715 McPherson Avenue</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>FEB 1 1961</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>		

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Lawrence J. Berlin*

Licensed Embalmer No. 8988

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.