

MAR 28 1961

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2548** STATE FILE NUMBER

DATE AMENDED
 ITEM NO.
 SHOULD READ
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT
 INSTEAD OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b 30 yrs.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1138 E. Grand

3. NAME OF DECEASED (Type or print) First SAM Middle Last MOSKOWITZ			4. DATE OF DEATH Month March Day 15 Year 1961		
5. SEX Male	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 11-1-1871	9. AGE (last birthday) 89	
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) Shoe Maker		10b. KIND OF BUSINESS OR INDUSTRY Shoe Manf.	11. BIRTHPLACE (City and state or country) Russia	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Abr. Moskowitz		13b. MOTHER'S MAIDEN NAME Edith (unk)		14. NAME OF HUSBAND OR WIFE Bertha	
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 Abr. moskowitz 7379 Amherst.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH 24 hr
Conditions, if any, which gave rise to above cause (a), (b), or (c) last 491X			
DUE TO (b) DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Arteriosclerotic Heart Disease			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 : Month, Day, Year a.m. p.m.

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
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21. I attended the deceased from **3/15/1961** to **March 15, 1961** and last saw ~~her~~ **him** alive on **March 15, 1961**
 Death occurred at **3** ^{**PM**} on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Warren J. Jacobson M.D.	22b. ADDRESS Jewish Hospital	22c. DATE SIGNED 3/15/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 3/17/61	23c. NAME OF CEMETERY OR CREMATORY B'nai Amoona	23d. LOCATION (City, town, or county) University City, Mo.
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24. FUNERAL DIRECTOR Berger Memorial 4715 MCPerson	25. DATE RECD. BY LOCAL REG. MAR 16 1961	26. REGISTRAR'S SIGNATURE Coal Smith, M.D.
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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 *[Handwritten Signature]*
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.