

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031310

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2267 STATE FILE NUMBER

AMENDED

FILED AUG 28 1961

DATE AMENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Olivette	a. STATE Missouri	b. COUNTY St. Louis
Length of stay in 1b YRS		c. CITY OR TOWN Olivette	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION #1 Bon Aire		d. STREET ADDRESS #1 Bon Aire	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First SARAH	Middle H.	Last GOLDFARB	4. DATE OF DEATH	Month August	Day 9	Year 1961
-------------------------------------	----------------	--------------	------------------	------------------	-----------------	----------	--------------

5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (last birthday) Abt. 64	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
------------------	---------------------------	---	-----------------------------	-----------------------------------	---------------------------	------------------------	-------	------

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

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Sol Goldfarb
-------------------------------	--------------------------------------	---

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. no	17. INFORMANT Sol Goldfarb-1 Bon Aire	Address
--	-------------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH 2 years
IMMEDIATE CAUSE (a) <i>Carcinoma of Thyroid</i>	
DUE TO (b) <i>metastases</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (c)	

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 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 <i>May 1960</i> to <i>Aug 9, 1961</i> and last saw her alive on <i>5PM- 8/9/61</i> Death occurred at <i>5:00 PM</i> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>Max J. Goldenroy, M.D.</i>	22b. ADDRESS <i>508 N. Grand</i>	22c. DATE SIGNED <i>8-9-61</i>
---	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE <i>8/11/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Chesed Shel Emeth Cem. St. Louis County, Missouri</i>	23d. LOCATION (City, town, or county) (State)
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <i>Herman Rindskopf, Inc. 5216 Delmar</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>8-10-61</i>	26. REGISTRAR'S SIGNATURE <i>John B. Mumfley M.D.</i>
---	---------	--	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 *Robert B. [Signature]*

Licensed Embalmer No. 3691

P. O. Address *[Signature]*

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.