

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
 AMENDED
 REGISTRATION DISTRICT NO. **318** PRIMARY REGISTRATION DISTRICT **1003** REGISTRAR'S NO. **8901** STATE FILE NUMBER **-61-034053**

FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 1 day	c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 730 Leland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ETHEL Middle BLOOM Last BLOOM			4. DATE OF DEATH Sept. 25, 1961 Month Sept. Day 25 Year 1961		
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5. SEX Female	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 unk	9. AGE (last birthday) ab 79	IF UNDER 1 YEAR Months ab 79 Days ab 79 Hours ab 79 Min. ab 79	IF UNDER 24 HR Hours ab 79 Min. ab 79
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Russia	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Aaron Bloom	13b. MOTHER'S MAIDEN NAME Sophie Efrom	14. NAME OF HUSBAND OR WIFE Nathan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown); (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Jos. N. Bloom 12309 Crystal View Lane
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 day number of years undetermined
DUE TO (b) Generalized arteriosclerosis		
DUE TO (c) 331 X		
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 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 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
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21. I attended the deceased from June 10, 1953 to Sept. 25, 1961 and last saw her him alive on 9/25/61 Death occurred at 11 P on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE E. J. Hance (Degree or title) W. D.	22b. ADDRESS 4652 Maryland	22c. DATE SIGNED 9/24/61 (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 9/28/61	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	23d. LOCATION (City, town, or county) University City, Mo.
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24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson	25. DATE RECD. BY LOCAL REG. SEP 26 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 *Quinn P. Anderson*
Licensed Embalmer No. 4289

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.