

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-034463
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8361

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Length of stay in 1b _____
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Ladue Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 3 Almont Acres Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
ALAN JAY HONIGBERG

4. DATE OF DEATH Month Day Year
SEPTEMBER 7 1961

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 7/4/39 9. AGE (last birthday) 22 IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

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

13a. FATHER'S NAME SAMUEL HONIGBERG 13b. MOTHER'S MAIDEN NAME Bernice 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. 16. SOCIAL SECURITY NO. Unk. 17. INFORMANT Mr. S. Honigberg Address 3 Almont Acres

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SUBACUTE GLOMERULONEPHRITIS WITH UREMIA INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
DUE TO (b) _____
DUE TO (c) 591x

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 AUGUST 15, 1961 to SEPTEMBER 7, 1961 last saw her alive on SEPTEMBER 7, 1961
Death occurred at 11:25 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. D. Vermillion, M.D. (Degree or title) M. D. 22b. ADDRESS BARNES HOSPITAL 22c. DATE SIGNED 9/8/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 9/10/61 23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol 23d. LOCATION (City, town, or county) (State) St. Louis County Missouri

24. FUNERAL DIRECTOR Herman Rindskopf Inc. 5216 Delmar ADDRESS _____ 25. DATE RECD. BY LOCAL REG. SEP 8 1961 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATE OF MISSOURI

DEPARTMENT OF HEALTH

EMERALD STATE

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 John Ketter
Licensed Embalmer No. 38850
P. O. Address St. Louis

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.