

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-003950

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 141

STATE FILE NUMBER

AMENDED

FILED JAN 11 1962

DATE AMENDED

INSTEAD OF

ITEM NO.

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		a. STATE <u>Mo.</u>	b. COUNTY <u>St. Louis</u>
Length of stay in 1b <u>1 wk.</u>		c. CITY OR TOWN <u>Olivette</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>9486 Olive St. Rd.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>BARNEY (AKA BENJAMIN)</u>	Middle <u>HURWITZ</u>	Last	4. DATE OF DEATH	Month <u>JANUARY</u>	Day <u>3</u>	Year <u>1962</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/1910</u>	9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Feather Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale feathers</u>	11. BIRTHPLACE (City and state or country) <u>Boston, Mass.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		

13a. FATHER'S NAME <u>Samuel Hurwitz</u>	13b. MOTHER'S MAIDEN NAME <u>Sophie Morgan</u>	14. NAME OF HUSBAND OR WIFE <u>Lillian</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unk.</u>	17. INFORMANT <u>Lillian Hurwitz</u>	Address <u>9486 Olive St. Rd.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>SUSPECTED GLIOBLASTOMA OF LEFT TEMPORAL LOBE</u>		<u>2 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	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)	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 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.)
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20c. TIME OF INJURY	Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 DECEMBER 3, 1961 to JAN. 3, 1962 and last saw her/him alive on JANUARY 3, 1962
Death occurred at 9:15 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>1/1/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u>	23b. DATE <u>1/5/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>	23d. LOCATION (City, town, or county) <u>University City, Mo.</u>	(State)
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24. FUNERAL DIRECTOR <u>Berger Memorial</u>	ADDRESS <u>4715 Cherson</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 5 1962</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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

Quinn G. Audwing

Licensed Embalmer No. 4229

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.