

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008034

STATE FILE NUMBER

318 Primary Registration District No. 1003 Registrar's No. 1937

Registration District No. FILED FEB 23 1962

AMENDED

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY <i>St. Louis</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | Length of stay in 1b 11 mos | 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 Hospital | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS 855 Westgate | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|---------------------------|---|--|--|---|------------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last Goldie Finn | | | 4. DATE OF DEATH Month Day Year Feb. 15 1962 | | | |
| 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 May 1884 | 9. AGE (last birthday) 77 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (City and state or country) USSR | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME Abraham Indictor | | 13b. MOTHER'S MAIDEN NAME (unknown) | | 14. NAME OF HUSBAND OR WIFE Jacob | | |
| 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 Address Sam Finn # 8 Knob Hill 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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Creミア</u> | | 1 year |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Arteriosclerosis</u> | many years |
| | DUE TO (c) <u>446x</u> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease, decompensated</u> | | 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 | |
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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.) | |
| 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 3/23/61 to 2/15/62 and last saw ^(her)him alive on 2/15/62
Death occurred at 10³⁰P on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Oloven S. Wenner, M.D.</u> | (Degree or title) | 22b. ADDRESS <u>8112 Delmar</u> | 22c. DATE SIGNED <u>2/16/62</u> |
|---|-------------------|------------------------------------|------------------------------------|

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|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>2-18-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>FEB 16 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> |
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 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 *Lawrence J. Kocian*

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.