MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-013118
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3683

FILED APR 12 1962

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 65 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Jewish Center for Aged
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): 1438 E. Grand
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First ESTHER Middle Last RIFKIN
4. DATE OF DEATH: Month April Day 8 Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH: 5/16/1882
9. AGE (last birthday): 79
IF UNDER 1 YEAR: Months Days
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
11. BIRTHPLACE (City and state or country): Russia
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Levi Ellman
13b. MOTHER'S MAIDEN NAME: Sima (unk)
14. NAME OF HUSBAND OR WIFE: Rubin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Louis Rifkin Address: 6023 Washington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INANITION — INTERVAL BETWEEN ONSET AND DEATH: 2 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS — Several years
DUE TO (c) 334x
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 [X] Unknown [ ]

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
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 7-1-60, to 4-8-62 and last saw her/him alive on 4-5-62
Death occurred at 5:15 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert S. Mandelbaum, M.D. (Degree or title)
22b. ADDRESS 4652 Maryland
22c. DATE SIGNED 4-8-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Rem.
23b. DATE: 4/8/1962
23c. NAME OF CEMETERY OR CREMATORY: Chesed Shel Emeth
23d. LOCATION (City, town, or county) (State): University City, Mo.

24. FUNERAL DIRECTOR: Berger Memorial ADDRESS: 4715 McPherson
25. DATE RECD. BY LOCAL REG.: APR 8 1962
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
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2	2 09		
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4	1		
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12	86-0		
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BY AFFIDAVIT OF DOCUMENT

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 Denis G. Judwig

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.