

FILED JUL 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21684

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5321**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo/</b> b. COUNTY <b>Ass</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>		d. STREET ADDRESS (If rural, give location) <b>21 3021a Dickson</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Rose</b> b. (Middle) <b>SIGEL</b> c. (Last) <b>Siegel</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 19, 1949</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Unk.</b>	9. AGE (In years last birthday) <b>9870</b>	IF UNDER 1 YEAR Months Days	IF UNDER 48 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done in life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Abr. Zuckerman</b>		13b. MOTHER'S MAIDEN NAME <b>Unk.</b>		14. NAME OF HUSBAND OR WIFE <b>Sam Sigel 3021a Dickson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Sam Sigel 3021a Dickson</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		<b>24 hrs.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive - Arteriosclerotic Heart Disease</b> <b>10 yrs</b> DUE TO (c) <b>Diabetes Mellitus</b> <b>15 yrs</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>1st Mo</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>2nd</b>	

22. I hereby certify that I attended the deceased from 18 Jun, 1949, to 19 Jun, 1949, that I last saw the deceased alive on 19 Jun, 1949, and that death occurred at 3:50 a. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Moms. Alex. M.D.</b> (Degree or title) <b>U</b>	23b. ADDRESS <b>216 So. Kingshighway</b>	23c. DATE SIGNED <b>19 Jun 49</b>
24a. BURIAL, CREMATION (Specify) <b>Buried</b>	24b. DATE <b>6/20/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>B'nai Amoona</b>
		24d. LOCATION (City, town, or county) (State) <b>University City Mo.</b>

DATE REC'D BY LOCAL HEALTH DEPT. <b>JUN 20 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Lester</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Berger Memorial 4715 McPherson</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

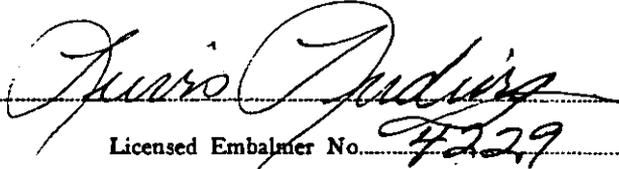
**STATEMENT BY LICENSED EMBALMER**

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 .....  
Student Embalmer

Signed  \_\_\_\_\_

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 this body is not embalmed, fact should be so stated above.