

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28534**
6934

FILED AUG 20 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) 39 yrs d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY D D c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 1396a Hamilton d. STREET ADDRESS (If rural, give location) St. Louis			
3. NAME OF DECEASED a. (First) YETTA b. (Middle) _____ c. (Last) SCISSORS (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year) Aug. 9, 1949			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9. AGE (In years if under 1 year; less birthdays) Months Days Hours Min. ab. 65		
10a. USUAL OCCUPATION (Give kind of work done during most of working life; or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME David Kash		13b. MOTHER'S MAIDEN NAME unk	14. NAME OF HUSBAND OR WIFE Max		
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. _____	17. INFORMANT'S SIGNATURE OR NAME Charles Scissors ADDRESS 7021a Amherst			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Lung, Left with Bronchial Occlusion and Collapse of Left Lung DUE TO (c) Arteriosclerosis, Generalized		INTERVAL BETWEEN ONSET AND 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) 4712	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 163X				
22. I hereby certify that I attended the deceased from 8/1 , 19 49 , to 8/9 , 19 49 , that I last saw the deceased alive on 8/8 , 19 49 , and that death occurred at 7:30A m., from the causes and on the date stated above.					
23a. SIGNATURE Roy Greenbaum MD (Degree or title)		23b. ADDRESS 508 n. Grand		23c. DATE SIGNED 8/9/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/10/49	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	24d. LOCATION (City, town, or county) (State) University City, Mo		
DATE REC'D BY LOCAL REG. AUG 9 1949		REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial 4715 McPherson ADDRESS		

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 *Lewis L Ludwig*

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.