

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39077

State File No. 9518

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) 52 yrs.		d. STREET ADDRESS (If rural, give location) 5817 Pershing	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp. U			

3. NAME OF DECEASED (Type or Print) a. (First) JACOB	b. (Middle)	c. (Last) MOLDAFSKY	4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 12, 1889	9. AGE (In years last birthday) Months Days Hours Min. 60
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Michael Moldafsky	13b. MOTHER'S MAIDEN NAME Unk Unterberger	14. NAME OF HUSBAND OR WIFE Eva Goldberg Moldafsky
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, only in town) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Milton Moldafsky	ADDRESS 5817 Pershing
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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		INTERVAL BETWEEN ONSET AND DEATH 18 hrs 5 1/2 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral bronchopneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 8th nerve tumor DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION Mar 10, 1944	19b. MAJOR FINDINGS OF OPERATION 8th nerve tumor (left)	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis MO
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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? 1948
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22. I hereby certify that I attended the deceased from **Dec 8, 1943**, to **Nov 13, 1949**, that I last saw the deceased alive on **Nov 13, 1949**, and that death occurred at **5:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Frank Magidson MD	(Degree or title) MD	23b. ADDRESS 20 W. 11th	23c. DATE SIGNED 11-14-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/15/49	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Meth	24d. LOCATION (City, town, or county) (State) University City Mo.
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DATE REC'D BY LOCAL REG. NOV 15 1949	REGISTRAR'S SIGNATURE J. B. Casper	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial	ADDRESS 4715 McPherson
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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

James A. Judice
4529

Licensed Embalmer No. _____

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.