

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39135
16493

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)	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		a. STATE MO	b. COUNTY St. Louis
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If rural, give location) 411 Mission Ct.	

3. NAME OF DECEASED (Type or Print)	a. (First) DORA	b. (Middle) OFFSTEIN	c. (Last) OFFSTEIN	4. DATE OF DEATH (Month) (Day) (Year) Dec 5 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 1 - 1893	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) RUSSIA	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME MAX GLAZER	13b. MOTHER'S MAIDEN NAME Leah KRAMER	14. NAME OF HUSBAND OR WIFE SAM OFFSTEIN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Rose OFFSTEIN	ADDRESS 7251 Longwood Rd.
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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 3 mo.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lung		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) atherosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma also			

19a. DATE OF OPERATION 10-1-49	19b. MAJOR FINDINGS OF OPERATION Lung & tumor & bleed about Carcinoma	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 47th (St. Louis)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? 163X
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22. I hereby certify that I attended the deceased from Sept 6, 1949, to Dec 5, 1949, that I last saw the deceased alive on Dec 5, 1949, and that death occurred at 10:00 m., from the causes and on the date stated above.

22a. SIGNATURE Sam Jander M.D.	(Degree or title) M.D.	22b. ADDRESS 634 1/2 Grand	22c. DATE SIGNED 12-6-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 6 1949	24c. NAME OF CEMETERY OR CREMATORY Chesed Shol Emeth	24d. LOCATION (City, town, or county) (State) 1500 Olive St. St. Louis
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DATE REC'D BY LOCAL REG. OFFICE DEC 6 1949	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE Wenhandler	ADDRESS 5010 Enright
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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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.

Signed _____

W. J. Odenhandler

Licensed Embalmer No. _____

3669

Signed _____
Student Embalmer

P. O. Address _____

5010 Enright

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.