

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **5995**

FILED MAR 10 1950

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1859			
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 OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) 47 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		20 9/11			
d. FULL NAME OF HOSPITAL OR INSTITUTION JEWISH ORTODOX OLD HOME				d. STREET ADDRESS (If rural, give location) 1438 E. Grand					
3. NAME OF DECEASED a. (First) ANNA			b. (Middle) _____		c. (Last) BERGER		4. DATE OF DEATH (Month) (Day) (Year) Feb. 24, 1950		
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH unk		9. AGE (In years) (Month) (Day) (Hours) (Min.) 86 7/17	
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 (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Max Abr. Lerman			13b. MOTHER'S MAIDEN NAME Unk			14. NAME OF HUSBAND OR WIFE Louis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mrs. Carrie				ADDRESS 914 Eastgate	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Embolic Cerebral						INTERVAL BETWEEN ONSET AND DEATH _____	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Chronic Myocarditis DUE TO (c) Arteriosclerosis							
		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 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) 4221	
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? _____					
22. I hereby certify that I attended the deceased from March 1, 1947 to Feb. 24, 1950 (that I last saw the deceased alive on Feb. 24, 1950), and that death occurred at 8:05 P. m. , from the causes and on the date stated above.									
23a. SIGNATURE [Signature]				(Degree or title) MD		23b. ADDRESS 1918 Eastgate		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/26/50		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		24d. LOCATION (City, town, or county) University City		(State) MO.	
DATE REC'D BY LOCAL REG. FEB 26 1950		REGISTRAR'S SIGNATURE [Signature]			25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial		ADDRESS 4715 McPherson		

(Licensed Embalmer's Statement on Reverse Side)

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.

Student _____
Student Embalmer

Signed *Paul J. Juding*

Licensed Embalmer No. *4329*

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.