

FILED SEP 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28247

318

1003

State File No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. <u>7232</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>5 wks.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton</u>		<u>4452</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>416 Edgewood</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANN</u>		b. (Middle) <u>CAROLINE</u>		c. (Last) <u>HAIMANN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 24, 1950</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>Jan. 15, 1949</u>			
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Theo Haimann</u>			13b. MOTHER'S MAIDEN NAME <u>Ruth Treiman</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Theo Haimann</u>		ADDRESS <u>416 Edgewood</u>			
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) <u>MENINGITIS</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>TUBERCULOSIS</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>	
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) _____					
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? <u>O1OX</u>					
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>50</u> to <u>Aug 24, 1950</u> , that I last saw the deceased alive on <u>Aug 24, 1950</u> , and that death occurred at <u>12</u> from the causes and on the date stated above.									
23a. SIGNATURE <u>S. D. Cohen</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>15 N. BRENTWOOD</u>		23c. DATE SIGNED <u>8/24/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/25/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Mt. Sinai</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County</u>			
DATE REC'D BY LOCAL <u>Aug 25 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Sasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Berger Memorial</u>		ADDRESS <u>4715 McPherson</u>			

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

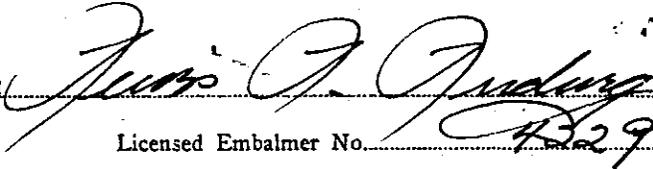
STATEMENT BY LICENSED EMBALMER

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.