

FILED OCT 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35407**
Registrar's No. **8281**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1005		State File No. 35407		Registrar's No. 8281			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Mo. b. COUNTY St. Louis							
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 55 yrs.		c. CITY OR TOWN University City		4366					
d. FULL NAME OF HOSPITAL OR INSTITUTION JEWISH HOSP.				d. STREET ADDRESS (If rural, give location) 7048 Tulane							
3. NAME OF DECEASED (Type or Print) Abraham AM			a. (First)			b. (Middle) UKMAN			c. (Last)		
4. DATE OF DEATH OCT. 1, 1950			7. DATE OF BIRTH Unk -			9. AGE (In years last birthday) ab 64			IF UNDER 1 YEAR: Months _____ Days _____		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Optician		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) USSR	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Louis Ukman		13b. MOTHER'S MAIDEN NAME Rose UNK		14. NAME OF HUSBAND OR WIFE Polgie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO.		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mr. Gustave Ukman							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		ANTECEDENT CAUSES								18 hrs	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.								6 wks.	
II. OTHER SIGNIFICANT CONDITIONS: Frac. Hip, left		Conditions contributing to the death but not related to the disease or condition causing death.								3 wks	
19a. DATE OF OPERATION Feb 1950		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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? F201-F							
22. I hereby certify that I attended the deceased from Feb , 19 50 , to Oct 1 , 19 50 , that I last saw the deceased alive on Oct 1 , 19 50 , and that death occurred at 12:30 p.m. , from the causes and on the date stated above.											
23a. SIGNATURE Mavis Cleef M.D.				(Degree or title) U				23b. ADDRESS 601 Humboldt Bldg		23c. DATE SIGNED 10/2/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/2/50		24c. NAME OF CEMETERY OR CREMATORY Chesed Shal Emeth		24d. LOCATION (City, town, or county) (State) University City Mo.					
DATE REC'D BY LOCAL REG. OCT 2 1950		REGISTRAR'S SIGNATURE J. B. Foster				25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial					
						ADDRESS 4715 McPherson					

WRITE PLAINLY—USING UNFAADING 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 *Quero A. Audberg*
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.