

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31878

State File No.

FILED SEP 21 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7470**

1. PLACE OF DEATH a. CITY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City		34 4346	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS 7018a Tulane			

3. NAME OF DECEASED (Type or Print) LOUIS			4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 1951		
a. (First)		b. (Middle)		c. (Last)	
				STEIN	

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 1 8 1914	9. AGE (In years last birthday) 36	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor	10b. KIND OF BUSINESS OR INDUSTRY Manf.	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Philip Stein	13b. MOTHER'S MAIDEN NAME Gussie Etzkow	14. NAME OF HUSBAND OR WIFE Edna
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 488-01-8044	17. INFORMANT'S SIGNATURE OR NAME Mrs. Edna Stein	ADDRESS 7018a Tulane
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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 10 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Glioblastoma of brain		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Glioblastoma of brain 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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 193X
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22. I hereby certify that I attended the deceased from **Sept 14**, 1951, to **8/20**, 1951, that I last saw the deceased alive on **8/20**, 1951, and that death occurred at **8:10pm.**, from the causes and on the date stated above.

23a. SIGNATURE I. J. Flance	(Degree or title) MD	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 8/21/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/22/51	24c. NAME OF CEMETERY OR CREMATORY Shesed Shel Emeth Cem.	24d. LOCATION (City, town, or county) (State) University City Mo.
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DATE RECD BY LOCAL REG. AUG 22 1951	REGISTRAR'S SIGNATURE W. L. S.	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial	ADDRESS 4715 McPherson
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(Licensed Embalmer's Statement on Reverse Side)

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

James G. Oudring
.....
Licensed Embalmer No. *4889*

Signed.....
Student Embalmer

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.