

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18300**
Registrar's No. **4464**

FILED JUN 6 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 6 WKS		2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION. Jewish Hsp.		d. STREET ADDRESS (If rural, give location) 1410 Montclair	

3. NAME OF DECEASED (Type or Print) SARAH MASHBEIN			4. DATE OF DEATH (Month) (Day) (Year) May 12, 1952		
a. (First)	b. (Middle)		c. (Last)		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 30, 1894		9. AGE (In years last birthday) 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Roumania	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Jos. Hillel		13b. MOTHER'S MAIDEN NAME Regina Unk		14. NAME OF HUSBAND OR WIFE William	
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. Mashbein 1410 Montclair	

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) Cerebral hemorrhage		DUE TO (b) malignant hypertension			2
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			6 mo.
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 checked="" type="checkbox"/>	
21a. 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	

22. I hereby certify that I attended the deceased from **5-1, 1952**, to **5-12, 1952**, that I last saw the deceased alive on **5-12, 1952**, and that death occurred at **7:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Helend Taylor MD		23b. ADDRESS 216 S Kings highway		23c. DATE SIGNED 5-13-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/14/52		24c. NAME OF CEMETERY OR CREMATORY B'nai Amoona	
				24d. LOCATION (City, town, or county) (State) University City Mo.	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 13 1952 Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4815 McPherson	
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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.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....

David J. Deidung
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.