

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7123**

FILED AUG 15 1952

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. STATE Missouri c. COUNTY 2059	
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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If rural, give location) 5 1294 Amherst Place	

3. NAME OF DECEASED (Type or Print) JACOB SOLOMON			4. DATE OF DEATH (Month) (Day) (Year) July 23, 1952		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Dec. 25, 1900		9. AGE (In years last birthday) 51		10. IF UNDER 1 YEAR: Months 6 Days 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (City and State or Foreign Country) New York City, N. Y.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Morris Solomon		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Audrey Solomon	
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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. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Jacob Solomon-1294 Amherst	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis Myocardial Separation Coronary Sclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) No.		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 4201	

22. I hereby certify that I attended the deceased from **7/11, 1952**, to **7/23, 1952**, that I last saw the deceased alive on **7/23, 1952**, and that death occurred at **1:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Arthur E. Smith, M.D.		23b. ADDRESS 539 N. Grand		23c. DATE SIGNED 7/24/52	
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24a. BURIAL, CREMATION, REMOVAL Removal		24b. DATE 7/25/52		24c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol Cem.	
				24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	

DATE RECEIVED BY LOCAL HEALTH DEPT. OR REG. JUL 24 1952		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 5216 Webster St.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2-300
2-48

30667

STATEMENT BY LICENSED EMBALMER

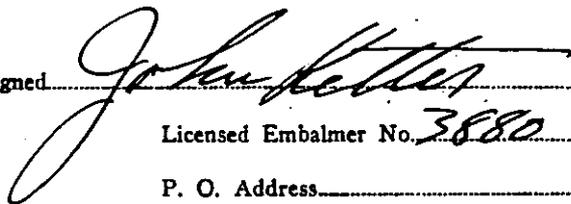
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 3880

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.