

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH36966  
State File No. \_\_\_\_\_

OCT 21 1952

318

1003

Registrar's No. 9237

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2159 M	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Jewish Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>15 4676 Louisiana</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Pearl Wahl</u> b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 3, 1952</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 13, 1883</u>		9. AGE (in years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife - widowed</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo. N</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>John Barsloue</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Frank Wahl</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank Wahl 4676 Louisiana</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis and cerebral Arteriosclerosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Resection of Left Colon for Carcinoma</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u>  <u>3 weeks</u>
19a. DATE OF OPERATION <u>9/19 &amp; 9/24</u>		19b. MAJOR FINDINGS OF OPERATION <u>Unilateral Nerve Carcinoma of Left Colon</u>				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? <u>4201</u>			
22. I hereby certify that I attended the deceased from <u>9/24/1952</u> , to <u>10/4/1952</u> , that I last saw the deceased alive on <u>10/3/52</u> , and that death occurred at <u>650p m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Oliver Goodhart, M.D.</u>				23b. ADDRESS <u>457 N. Kings Highway</u>		23c. DATE SIGNED <u>10/4/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>10-7-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>OCT 6 1952</u>		REGISTRAR'S SIGNATURE <u>J. C. Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Southern Funeral Home</u>		ADDRESS <u>6322 S. Grand Blvd</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Goldfarb  
457 N. Kingshighway,  
Ro. 3116

1 to 2 Saturday

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**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 \_\_\_\_\_

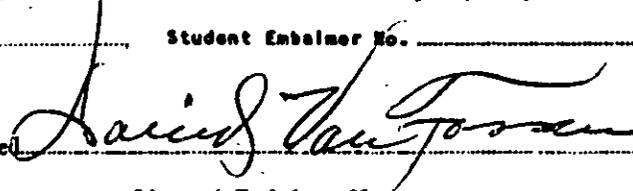
Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed



Licensed Embalmer No. \_\_\_\_\_

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.