S. No. 300
v. 10.48

FILED NOV 12 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37134

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 546 Registrar's No. 2542

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Overland
c. LENGTH OF STAY (in this place) 2 months 25
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Dennison Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 2259
d. STREET ADDRESS (If rural, give location) Stag. Pacific Hotel

3. NAME OF DECEASED (Type or Print)
a. (First) Joseph
b. (Middle)
c. (Last) BLUMBERG

4. DATE OF DEATH (Month) Sept (Day) 30 (Year) 1952

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 1
8. DATE OF BIRTH unk
9. AGE (In years last birthday) at 80 | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY retail
11. BIRTHPLACE (State or foreign country) Unknown 9
12. CITIZEN OF WHAT COUNTRY? unk

13a. FATHER'S NAME unk
13b. MOTHER'S MAIDEN NAME unk
14. NAME OF HUSBAND OR WIFE Anna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unk
17. INFORMANT'S SIGNATURE OR NAME Chester Blumberg 1421 Farwell ADDRESS Chicago

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-pneumonia, terminal — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 334X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/5, 1952, *to* present, 19__, *that I last saw the deceased alive on* 9/22, 1952, *and that death occurred at* 9:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Samuel E. Schechter (Degree or title) M.D.
23b. ADDRESS 634 N. Grand
23c. DATE SIGNED 10-1-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 5
24b. DATE 10/2/52
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Indianapolis Ind

DATE REC'D BY LOCAL REG. 10-2-52
REGISTRAR'S SIGNATURE Herbert R. Domke MD
25. FUNERAL DIRECTOR'S SIGNATURE Bryan Memorial ADDRESS 4115 Mt Avon

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 29 1953

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 Jesse J. Ludwig

Licensed Embalmer No. 4559

P. O. Address.....

Signed.....
Student Embalmer

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.