

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26833

FILED JUL 31 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 67772

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (In this place) <u>4 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>4947 Cote Brilliante</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bernard Nursing Home</u>		3. NAME OF DECEASED a. (First) <u>JENNIE</u> b. (Middle) <u>ROSENBLUM</u> c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) <u>July 8 1953</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>Mar. 24, 1872</u>		9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR: Months _____ Days _____ IF OVER 1 YEAR: Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Indianapolis, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>David Frey</u>		13b. MOTHER'S MAIDEN NAME <u>Sophie Herz</u>	
14. NAME OF HUSBAND OR WIFE <u>Jonas Rosenblum</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Irl B. Rosenblum</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, asthma, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio-Sclerotic Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pneumonia</u> 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 checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
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)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>420.0</u>	
22. I hereby certify that I attended the deceased from <u>7/2</u> , 19 <u>53</u> , to <u>7/8</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7/8</u> , 19 <u>53</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Herman M. Meyer M.D.</u>		23b. ADDRESS <u>4409 West Pine (8)</u>	
23c. DATE SIGNED <u>7/8/53</u>		24. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>7/9/53</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>	
DATE REC'D BY LOCAL REG. <u>JUL 9 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u> Berger Memorial</u>		ADDRESS <u>4715 McPherson</u>	

M.D.B. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY - USING UNFADING INK

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

James A. Anderson
Licensed Embalmer No. 4529

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.