

FILED AUG 20 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29743  
Registrar's No. 7478

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Mo. b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis                               |  |
| c. LENGTH OF STAY (In this place)<br>24 yrs.                                      |  | d. STREET ADDRESS (If rural, give location)<br>9 1438 E. Grand  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>Jewish Hospital                        |  |   |  |

|  |                           |   |  |  |                            |                                      |
|--|---------------------------|---|--|--|----------------------------|--------------------------------------|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) PHILIP b. (Middle) APPLESTEIN c. (Last)              |                           |   | 4. DATE OF DEATH (Month) (Day) (Year)<br>July 31, 1953 |  |                            |                                      |
| 5. SEX<br>Male <input type="radio"/>   | 6. COLOR OR RACE<br>White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Widowed | 8. DATE OF BIRTH<br>unk.                               | 9. AGE (In years last birthday)<br>ab 92                   | # UNDER 1 YEAR Months Days | # UNDER 10 YRS. Hours Min.           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Feddler |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Fish                         |  | 11. BIRTHPLACE (City and State or Foreign Country)<br>USSR |                            | 12. CITIZEN OF WHAT COUNTRY?<br>USSR |

|  |  |                                   |  |  |  |
|--|--|-----------------------------------|--|--|--|
| 13a. FATHER'S NAME<br>Applestein   |  | 13b. MOTHER'S MAIDEN NAME<br>Unk. |  | 14. NAME OF HUSBAND OR WIFE<br>Frieda  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>NO |  | 16. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>Mr. Louis Applestein 3840 Olive |  |

|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |  | INTERVAL BETWEEN ONSET AND DEATH<br><br>35 days |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis  |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) wound dehiscence<br>DUE TO (c) Volvulus |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |   |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>2 July 53             |  | 19b. MAJOR FINDINGS OF OPERATION<br>Volvulus sigmoid   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input 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)<br>570, 3                           |  |
| 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?  |  |

22. I hereby certify that I attended the deceased from 2 July, 1953, to 31 July, 1953, that I last saw the deceased alive on 31 July, 1953, and that death occurred at 8:20 P.M., from the causes and on the date stated above.

|   |  |                                 |  |   |  |
|---|--|---------------------------------|--|---|--|
| 23a. SIGNATURE (Degree or title)<br>London M.D.             |  | 23b. ADDRESS<br>Jewish Hospital |  | 23c. DATE SIGNED<br>31 July 53                            |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal        |  | 24b. DATE<br>8/2/53             |  | 24c. NAME OF CEMETERY OR CREMATORY<br>Beth Hamedrosh Hag. |  |
| 24d. LOCATION (City, town, or county) (State)<br>Ladue, Mo. |  |                                 |  |   |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG.<br>AUG 1 1953 |  | REGISTRAR'S SIGNATURE<br>J. Earl Smith, M.D. |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br>Berger Memorial 4715 McPherson |  |
|--|--|--|--|--|--|

WRITE PLAINLY—USING UNFAADING 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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Quirino A. Juduiza*  
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.