

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

33284  
8167

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED OCT 1 - 1953

1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN UNIVERSITY CITY 376	
d. FULL NAME OF HOSPITAL OR INSTITUTION JEWISH HOSPITAL		d. STREET ADDRESS (If rural, give location) 8018 STANFORD	

3. NAME OF DECEASED (Type or Print) a. (First) ROSE b. (Middle) GOLDBERG c. (Last) GOLDBERG	4. DATE OF DEATH (Month) (Day) (Year) AUG-22-1953
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH UNKNOWN	9. AGE (In years) (Months) (Days) ABT. 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	11. BIRTHPLACE (City and State or Foreign Country) AUSTRIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (City and State or Foreign Country) AUSTRIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ADOLPH FREMDER	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE LEON GOLDBERG
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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 DAVID GOLDBERG	ADDRESS 6018 STANFORD - U. CITY
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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, athermia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Fracture of right arm; Fr of right hip; asteris schuss ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (a) when she fell at the Jewish Sanitarium in Aug lum, Mo.		INTERVAL BETWEEN ONSET AND DEATH
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. on Aug 19, 1953, exact acute tubercular		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Accident	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) Accident SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Sanitarium	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Aug lum, Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 19 58	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? E904.7

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_, 19\_\_\_\_, from the causes and on the date stated above.

23a. SIGNATURE M. P. [Signature]	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 8/24/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE AUG-24-1953	24c. NAME OF CEMETERY OR CREMATORY BNAI AMOONA CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.
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DATE REC'D BY LOCAL REG. AUG 24 1953	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Norman Rindick	ADDRESS 5216 DELMAR
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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 *John Ketter*

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.