

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40206

FILED NOV 24 1953

State File No.

318

1003

Registrar's No. 10451

BIRTH MO. _____ REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 47 yrs.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		e. STREET ADDRESS (If rural, give location) 1425 Semple Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Rae b. (Middle) _____ c. (Last) Block		4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 1888
9. AGE (In years last birthday) ab 65		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) Unknown
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hershel Sandstein	
13b. MOTHER'S MAIDEN NAME Edie Handelman		14. NAME OF HUSBAND OR WIFE Hymen Block	
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. None	
17. INFORMANT'S SIGNATURE OR NAME Hymen Block		ADDRESS 1425 Semple Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction, with strangulation		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES Umbilical hernia, incarcerated - 7 mos			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
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 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 5705			
22. I hereby certify that I attended the deceased from 10/9, 1953 , to time of death , that I last saw the deceased alive on 11/2, 1953 , and that death occurred at 7:35 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Carl Smith M.D. (Degree or title)		23b. ADDRESS 462 N. Taylor	
23c. DATE SIGNED 11/2/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11/4/1953	
24c. NAME OF CEMETERY OR CREMATORY B'nai Amoona		24d. LOCATION (City, town, or county) (State) University City, Mo.	
DATE REC'D BY LOCAL REG. NOV 4 1953		25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial ADDRESS 4715 McPherson Ave.	

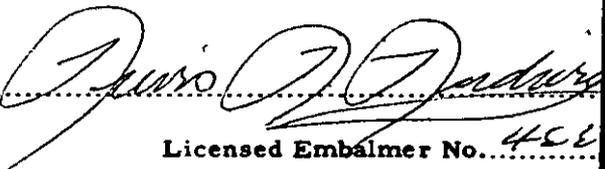
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1901

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.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 422.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.