

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **2819**
Registrar's No. **0106**

LED JAN 26 1954

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 Mo. b. COUNTY 2129	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 4 days		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 Hosp.			
e. STREET ADDRESS (If rural, give location) 4907 Maryland Ave. Fairmont Hotel			

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) c. (Last) GOLDBERG			4. DATE OF DEATH (Month) (Day) (Year) Jan. 4, 1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Div.	
8. DATE OF BIRTH Ab 1875		9. AGE (In years last birthday) ab 78		10. IF UNDER 1 YEAR Months 11. 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 Furn.		11. BIRTHPLACE (City and State, or Foreign Country) England	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Solomon Goldberg		13b. MOTHER'S MAIDEN NAME Goldie Laski	
14. NAME OF HUSBAND OR WIFE		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. 329-10-4198	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Lena Cohnberg		ADDRESS 415 N. Pröce Rd.			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lung with metastasis to liver and regional lymph nodes		DUPLICATE TO (b) 4 mo		DUPLICATE TO (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.		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 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)	
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 163X	

22. I hereby certify that I attended the deceased from **Sept. 1, 1953**, to **Jan. 4, 1954**, that I last saw the deceased alive on **Jan. 4, 1954**, and that death occurred at **6:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Jos. M. Orenstein, M.D.		23b. ADDRESS 4500 Olive St.		23c. DATE SIGNED Jan 4, 1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		24b. DATE 1/7/54		24c. NAME OF CEMETERY OR CREMATORY B'nai Amooha	
24d. LOCATION (City, town, or county) (State) University City, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial			
25. ADDRESS 4715 McPherson		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 6 1954			

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.