

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28895**
7371

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporating town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 2 1/2 yrs		e. STREET ADDRESS (If rural, give location) 1438 E. Grand	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1438 E/Grand			

3. NAME OF DECEASED (Type or Print) a. (First) ABRAHAM b. (Middle) c. (Last) FRIEDMAN		4. DATE OF DEATH (Month) (Day) (Year) Aug. 9, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid.	8. DATE OF BIRTH Ab 1874
9. AGE (In years last birthday) ab. 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.	11. BIRTHPLACE (City and State or Foreign Country) Unk.
12. CITIZEN OF WHAT COUNTRY? UNK.			

13a. FATHER'S NAME Unk.	13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE Unk.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. B. Winfield 1438 E. Grand

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, Coronary 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"/>
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 331X

22. I hereby certify that I attended the deceased from 10, 1954, to 8/9, 1954 that I last saw the deceased alive on 8/5, 1954, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Roy Greenbaum M.D.		23b. ADDRESS 4652 Maryland		23c. DATE SIGNED 8/9/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	24b. DATE 8/9/54	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	24d. LOCATION (City, town, or county) (State) University City Mo.	
DATE REC'D BY LOCAL REG. AUG 9 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson		

WRITE PLAINLY—USING UNFADING 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.....
Signature of Student Embalmer

Signed *Quis A. Quis*.....
Licensed Embalmer No. 4339

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.