FILED JUN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20370

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5250

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis
c. LENGTH OF STAY (in this place): 30 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jewish Orthodox Old Fks. H. 27

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
STREET ADDRESS (If rural, give location): 1438 N. Grand

3. NAME OF DECEASED (Type or Print)
a. (First): Rachel
b. (Middle): Leah
c. (Last): Saiger

4. DATE OF DEATH (Month) (Day) (Year): June 16, 1955

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Wid.
8. DATE OF BIRTH: Unk.
9. AGE (In years last birthday): Ab 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country): USSr
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Abraham Tessler
13b. MOTHER'S MAIDEN NAME: Sarah *----
14. NAME OF HUSBAND OR WIFE: Samuel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Si Saiger
ADDRESS: 5622 Delmar

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage with Right Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 6/10/55

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) Arteriosclerosis, Gen.

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 ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

331X

22. *I hereby certify that I attended the deceased from* 10, 1953 *to* 6/16, 1955, *that I last saw the deceased alive on* 6/14, 1955, *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Roy Greenbaum MD
23b. ADDRESS: 4652 Maryland
23c. DATE SIGNED: 6/17/55

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem.
24b. DATE: 6/19/55
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.: JUN 17 1955
REGISTRAR'S SIGNATURE: J. Carl Smith MD
a.m.

25. FUNERAL DIRECTOR'S SIGNATURE: Berger Memorial
ADDRESS: 4715 MCPherson

(Licensed Embalmer's Statement on Reverse Side)

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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No...

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.