

FILED AUG 26 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27418

State File No. ....

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6359

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6359				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis				c. LENGTH OF STAY (in this place) 5 yrs.		c. CITY OR TOWN 43361 University City		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 Orthodox Old Folks Home				STREET ADDRESS (If rural, give location) 6313 Cabanne						
3. NAME OF DECEASED (Type or Print) LOUIS		a. (First)		b. (Middle)		c. (Last) ARNOWITZ		4. DATE OF DEATH (Month) (Day) (Year) July 22, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid.		8. DATE OF BIRTH Ad 1873		9. AGE (In years last birthday) 67 1/2		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (City and State or Foreign Country) USSR		12. CITIZEN OF WHAT COUNTRY? USSR				
13a. FATHER'S NAME Arnowitz			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE Dora				
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 Mr. Louis Arnowitz		ADDRESS 524 Park				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pyelonephritis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prostatic hypertrophy</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis, Generalized</u>						INTERVAL BETWEEN ONSET AND DEATH 2 months		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 610X						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?						
22. I hereby certify that I attended the deceased from <u>10</u> , 19 <u>53</u> , to <u>7/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P. m.</u> , from the causes and on the date stated above.										
23a. SIGNATURE <u>Ray Greenbaum</u>				(Degree or title) <u>MD</u>		23b. ADDRESS <u>4652 Maryland</u>		23c. DATE SIGNED <u>7/23/55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		24b. DATE <u>7/24/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Beth Ham, Hagodol</u>		24d. LOCATION (City, town, or county) (State) <u>Ladue, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>JUL 25 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Berger Memorial</u>		ADDRESS <u>4715 McPherson</u>			

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 .....  
Licensed Embalmer No. 425

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.