

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42619

FILED DEC 27 1956

318

1003

STATE FILE NUMBER

11288

Registration District No. Primary Registration District No. Registrar's No.

| | | | | | | | | | | | | | |
|---|--|---|----------------------|---|---|---|--|--|--|--|--|------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u> | | | Length of stay in 1b | | d. STREET ADDRESS (If outside, give location) <u>4605 Lindell Blvd</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>R. Aloe</u> Last | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>56</u> | | | | | | | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 7, 1875</u> | | 9. AGE (In years last birthday) <u>81</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Meyer Rosenblatt</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Clara Bauman</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>Howard Baer 45 Portland Pl.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary art. thromboses</u> DUE TO (b) <u>Art. Scler. Cardio Vasc. Dis</u> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>20 yrst</u> | | | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>420.1</u> | | | | | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year <u>9:30 a.m. 12/8/56</u> | | | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | | | | |
| 21. I attended the deceased from <u>June 2, 1946 death</u> and last saw her <u>alive on 12/8/56</u> Death occurred at <u>939 am</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Norman W. Deerp MD</u> | | | | | | 22b. ADDRESS <u>634 N. Grand</u> | | | | 22c. DATE SIGNED <u>12/9/56</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE <u>12/10/56</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u> | | | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co Mo.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Mayer</u> ADDRESS <u>4356 Lindell Blvd</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>DEC 10 1956</u> | | | | 26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>m 8/16</u> | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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MAY 5 4 1958

MAY 2 1958

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 *John D. ...*

Licensed Embalmer No. *34*
P. O. Address *St. La.*

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