

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 18 1956

State File No. **43617**
10776

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. LENGTH OF STAY (in this place) 10 days | c. CITY OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp. | | e. STREET ADDRESS (If rural, give location) 2121 1/2 5573 Delmar | |

| | | | | | | |
|--|-------------------------------|--|-------------|--|---|--|
| 3. NAME OF DECEASED (Type or Print) BARNEY | | a. (First) | b. (Middle) | c. (Last) NEWMARK | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 25, 1956 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | | 8. DATE OF BIRTH April 14-1886 | 9. AGE (In years last birthday) 70 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Owner of shop | | 11. BIRTHPLACE (City and State or Foreign Country) USSR | | 12. CITIZEN OF WHAT COUNTRY? USA |

| | | |
|--|--|--|
| 13a. FATHER'S NAME Samuel J. Newmark | 13b. MOTHER'S MAIDEN NAME Rose (unk) | 14. NAME OF HUSBAND OR WIFE Bertha Newmark |
|--|--|--|

| | | | |
|---|--|--|-------------------------------|
| 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 Bertha Newmark | ADDRESS 5573 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, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart dis. with congestive failure | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. |
| | ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) with congestive failure | | |
| | 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 420.0 | 20. AUTOPSY? YES <input 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) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 50 11-25-56 |
|--|--|--|

22. I hereby certify that I attended the deceased from 19 50, to Nov 25, 19 56, that I last saw the deceased alive on 11-25, 19 56, and that death occurred at 1:30 m., from the causes and on the date stated above.

| | | | |
|--|-------------------|--------------------------------------|-------------------------------------|
| 23a. SIGNATURE Melvin B. Kerstein M.D. | (Degree or title) | 23b. ADDRESS 607 No. Grand | 23c. DATE SIGNED 11-25-56 |
|--|-------------------|--------------------------------------|-------------------------------------|

| | | | |
|---|------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 11/26/56 | 24c. NAME OF CEMETERY OR CREMATORY Mount Olive H. Cem. | 24d. LOCATION (City, town, or county) (State) Univ. City, Mo. |
|---|------------------------------|--|---|

| | | | |
|--|--|--|----------------------------------|
| DATE REC'D BY LOCAL REG. NOV 26 1956 | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial | ADDRESS 4715 McPherson |
|--|--|--|----------------------------------|

m-j-b. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10.48

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 *David G. Gudung*

Licensed Embalmer No... 4827

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.