

FILED APR 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15064**
Registrar's No. **3690**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 50 yrs.		e. STREET ADDRESS (If rural, give location) 199 1/2 4405 W. Pine	
d. FULL NAME OF HOSPITAL OR INSTITUTION 14 Jewish Hosp.		f. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) BECKIE b. (Middle) Axelbaum c. (Last) MOSKOW		4. DATE OF DEATH (Month) (Day) (Year) April 17, 1957	
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. 80	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) Housewife		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 Simon Kussner		13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE Isadore
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 ADDRESS Mr. Ben Axelbaum 7508 Wellington
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral artery thrombosis INTERVAL BETWEEN ONSET AND DEATH 5 mos. ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 3324	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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) (Min.)	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 11. 9. , 19 56 , to 4. 17. , 19 57 , that I last saw the deceased alive on 4. 27. , 19 57 , and that death occurred at 3A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Frank H. Steinlag, M.D.		23b. ADDRESS 462 No. Taylor	23c. DATE SIGNED 4/17/57
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	24b. DATE 4/18/57	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. APR 17 '57	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson	

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

