

FILED AUG 30 1957

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30154

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7256

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 14 Jewish Hosp.		Length of stay in lb 1 day		d. STREET ADDRESS 27 535 No. So. Blvd.	
3. NAME OF DECEASED (Type or print) SARAH WEINTRAUB		4. DATE OF DEATH Aug. 3, 1957		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1896	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days 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 country) USSR	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Sholom Schwartz		13b. MOTHER'S MAIDEN NAME Unk.	
14. NAME OF HUSBAND OR WIFE Morris		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 Morris Weintraub		Address 535 N 2 & S. Rd.		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 Occlusion</u> DUE TO (b) <u>Arteriosclerotic C-U Disease</u> DUE TO (c) <u>4201</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 University City, Mo.		COUNTY		STATE	
21. I attended the deceased from <u>Jan 1949</u> to <u>Aug 3, 1957</u> and last saw her alive on <u>Aug 2, 1957</u> . Death occurred at <u>3:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Maria Albert Rud</u>		22b. ADDRESS 601 Humboldt Blvd	
22c. DATE SIGNED Aug 3, 1957		23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		23b. DATE 8/4/57	
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		23d. LOCATION (City, town, or county) University City, Mo.		(State)	
24. FUNERAL DIRECTOR Berger Memorial		ADDRESS 4715 McPherson		25. DATE RECD. BY LOCAL REG. AUG 5 '57	
26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

*Quis G. Gudberg*

Licensed Embalmer No. 4229

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.