

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38194

STATE FILE NUMBER

FILED NOV 6 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9494

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN University City | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp. | | d. STREET ADDRESS 6263 Cabanne | |
| 3. NAME OF DECEASED (Type or print) First MAX Middle STEIN Last STEIN | | 4. DATE OF DEATH Oct. 9, 1957 | |
| 5. SEX Male | 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 Mar. 22, 1884 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser | | 11. BIRTHPLACE (City and state or country) USSR | |
| 13. FATHER'S NAME Leib Stein | | 14. MOTHER'S MAIDEN NAME Simcha (unk) | |
| 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. 492-10-7376 | |
| 17. INFORMANT Tillie Stein 6263 Cabanne | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200 | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 p. m. Month, Day, Year | | | |
| 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 Sept. 25, 1957 , to Oct. 8, 1957 and last saw her alive on Oct. 8, 1957 Death occurred at 7:40 p. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Alvin S. Wenzel, M.D. (Degree or title) | | 22b. ADDRESS 950 Francis Place | |
| 22c. DATE SIGNED 10/10/57 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | |
| Rem. | | 10/13/57 | |
| 23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth | | 23d. LOCATION (City, town, or county) (State) University City, Mo. | |
| 24. FUNERAL DIRECTOR Berger Memorial 4715 Mopherson ADDRESS | | 25. DATE RECD. BY LOCAL REG. OCT 11 57 | |
| 26. REGISTRAR'S SIGNATURE Earl Smith MO | | | |

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

MEDICAL CERTIFICATION

Health & Welfare Public Health Service

300 1-56

No. 102-107376
 State of Ohio
 License No. 1884
 Date of Issue Oct. 2, 1937
 Issued to: [Name] (M) [Address]
 [Name] [Address]
 [Name] [Address]
 [Name] [Address]
 [Name] [Address]

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 *[Signature]*
 Licensed Embalmer No.

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.