

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030857

STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar No. 8134

5. 300
1-57

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 61 5939 Washington		Length of stay in lb 12 1/2 yrs		d. STREET ADDRESS (If outside, give location) 5939 Washington		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First NATHAN Middle Last POMERANTZ				4. DATE OF DEATH Month Aug. Day 20 Year 1958		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. 5, 1903		9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during last week or last month if retired) barber cutter		11. BIRTHPLACE (City and state or country) Poland		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Unk. Pomerantz		13b. MOTHER'S MAIDEN NAME Unk.		14. NAME OF HUSBAND OR WIFE Fannie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (shown) in war or dates of service)		16. SOCIAL SECURITY NO. 492-32-0095		17. INFORMANT Address Fannie Pomerantz 5939 Washington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease myocardial infarction DUE TO (b) 420.0 DUE TO (c) 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			
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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.			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 7-17-58 to 6-28-58 and last saw him alive on 6-28-58 Death occurred at 6/21/58 7:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE Joseph Levitt M.P.O.						22b. ADDRESS St. Louis Mo			22c. DATE SIGNED 8/22/58		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/22/58		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 W. Cherson				25. DATE RECD. BY LOCAL REG. AUG 21 58		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.					

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Edward J. Davis*.....

Licensed Embalmer No. 3988.....

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.