

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002728

STATE FILE NUMBER 100

FILED JAN 26 1959

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN XXXX St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Length of stay in lb 2067 STREET ADDRESS 5949 Hamilton Ter. (If outside, give location)	
3. NAME OF DECEASED (Type or print) First MIDDLE Last HARRY BENSON		4. DATE OF DEATH Month Day Year January 5, 1959	
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 April 20, 1900 Unknown
9. AGE (In years last birthday) Abt. 58		10. KIND OF BUSINESS OR INDUSTRY Merchant	11. BIRTHPLACE (City and state or country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown Mochtcha Benenson	
14. MOTHER'S MAIDEN NAME Unknown Nahomia Bloom		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. 340-28-7665 Unknown		17. INFORMANT Mrs. H. Benson-5949 Hamilton Terr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(n) HEALED MYOCARDIAL INFARCTION.			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED ITEM 8, 9, 13, 14, 16 CORRECTED BY: 1. AFFIDAVIT OF <u>embalment</u> 2. DOCUMENT #3182877 E. St. Louis, Mo.		20c. TIME OF INJURY Hour Month, Day, Year a. m. 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 JAN. 9. 1956 to JAN 5. 1959 and last saw him alive on JAN 4/59 Death occurred at 9:50 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Frank Cohen M.D.		22b. ADDRESS 10577 St Charles Rock Rd ST ANN. MO	
22c. DATE SIGNED Jan 5/59		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 1/7/59		23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem. St. Louis County Mo.	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR Herman Rindskopf, Inc. 5216 Delmar	
25. DATE RECD. BY LOCAL REG. JAN 6 '59		26. REGISTRAR'S SIGNATURE C. E. Smith M.D. m.s.b.	

15
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Part I must be causally related. Cause cannot carry to a death due to natural causes. 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.....
[Handwritten Signature]

Licensed Embalmer No. *36*

P. O. Address *[Handwritten Address]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.