

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010746
STATE FILE NUMBER
2 1943

FILED MAR 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Olivette 4000		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul		Length of stay in lb 2 hrs.	d. STREET ADDRESS (If outside, give location) 732 Gralee Lane		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MERCEDES NOLA BRODDEN			4. DATE OF DEATH Month Day Year Feb. 23, 1959		
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 Nov. 25, 1908	9. AGE (In years last birthday) 50	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 country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Harry H. Goldman		13b. MOTHER'S MAIDEN NAME Pearl Oxenhandler		14. NAME OF HUSBAND OR WIFE Jacob	
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. 492-40-4322	17. INFORMANT Address Jacob Brodden 732 Gralee Lane		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>Posterior</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>4200</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4200</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>
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 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 <i>25 May 1947</i> to <i>2/23/59</i> and last saw her alive on <i>2/23/59</i> Death occurred at <i>St. Louis, Mo.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert Potashnick M.D.</i>			22b. ADDRESS <i>3720 Washington</i>		22c. DATE SIGNED <i>2/24/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Rem.</i>		23b. DATE <i>2/25/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Chesed Shel Emeth</i>		23d. LOCATION (City, town, or county) (State) <i>University City, Mo.</i>
24. FUNERAL DIRECTOR <i>Berger Memorial 4 715 McPherson</i>			25. DATE RECD. BY LOCAL REG. <i>FEB 24 '59</i>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

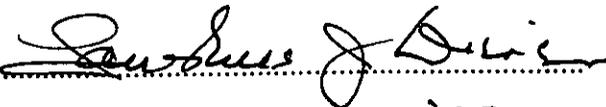
MEDICAL CERTIFICATION

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 

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.