

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011464

STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2115**

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY St. Louis City		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF (IF NOT in hospital, give location) Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 6270 Cabanne	
3. NAME OF DECEASED (Type or print) First Mollie Middle _____ Last Tullman		4. DATE OF DEATH Month Feb. Day 28, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
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
13a. FATHER'S NAME Pincus Richman		13b. MOTHER'S MAIDEN NAME Shosha	14. NAME OF HUSBAND OR WIFE Louis
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 Address Manuel Tullman 7807 Blackberry 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) Cerebral degeneration Conditions, if any, which gave rise to (b) pneumonia - broncho-bilateral Probable cause (if stating the terminal illness) renal failure + infection, Broken hip PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pt. was very ill from severe renal infection			INTERVAL BETWEEN ONSET AND DEATH 2-16-59 2-28-59
20a. ACCIDENT <input checked="" 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.) Fell from wheel chair while pt. in hospital	
20c. TIME OF INJURY Hour 1 p.m. Month, Day, Year 2-16-59		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Jewish Hospital		20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Missouri	
21. I attended the deceased from 2-16-59 to 2-28-59 and last saw ^{her} him alive on 2-27-59 Death occurred at 5:25 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leon J. Fox MD		22b. ADDRESS 634 No. Grand Ave.	
22c. DATE SIGNED 2-28-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-1-59	
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		23d. LOCATION (City, town, or county) (State) University City, Missouri	
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson		25. DATE RECD. BY LOCAL REG. 3-1-1959	
26. REGISTRAR'S SIGNATURE Leon Smith, M.D.			

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 *Not embalmed.*
Lewis L. Ludwig

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.