

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023298

STATE FILE NUMBER

25646

FILED JUL 3 1959

Registration District No. _____ Primary Registration District No. _____

Registration 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 University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS 6227 Northwood	
3. NAME OF DECEASED (Type or print) BERNARD		4. DATE OF DEATH Month Day Year June 12, 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 Nov. 8, 1899	
9. AGE (in years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naturalization Examiner	
11. BIRTHPLACE (City and state or country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Solomon Proser		13b. MOTHER'S MAIDEN NAME Minnie Lichtenstein	
14. NAME OF HUSBAND OR WIFE Ida Claire Proser		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ida Claire Proser 6227 Northwood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 200.2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 April 1959 to June 12, 1959 and last saw him alive on June 12, 1959 Death occurred at 4:55 pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Frank H. Heinberg M.D.		22b. ADDRESS 216 So. Kingshighway	
22c. DATE SIGNED 6/13/59			
23a. BURIAL, CREMATION, or other disposition (Specify) removal		23b. DATE 6-14-59	
23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson		25. DATED BY LOCAL REG. JUN 13 59	
		26. REGISTRAR'S SIGNATURE Earl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

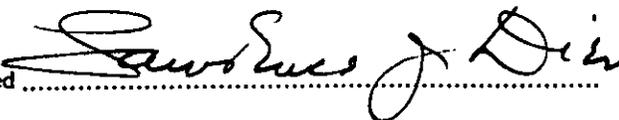
MEDICAL CERTIFICATION

U.S.

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.