

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023362

STATE FILE NUMBER
2 4805

Registration District No. _____ Primary Registration District No. _____ Registered No. _____

FILED JUN 19 1959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Clayton	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 6445 Alamo	

3. NAME OF DECEASED (Type or print) WILLIAM SAMUELS			4. DATE OF DEATH May 18, 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. 12, 1898	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Emp.		10b. KIND OF BUSINESS OR INDUSTRY Furn. Manf.	11. BIRTHPLACE (City and state or country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Louis Samuels		13b. MOTHER'S MAIDEN NAME Laura (unk)		14. NAME OF HUSBAND OR WIFE Frieda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, Ne known) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 497-05-6398	17. INFORMANT Frieda Samuels Address 6445 Alamo		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas		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) _____		
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 _____ 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 **Sept. 1952** to **5/18/59** and last saw him **alive** on **5/17/59**
Death occurred at **130 A** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. J. Hance (Degree or title) M.D.	22b. ADDRESS 4652 Maryland	22c. DATE SIGNED 5/18/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 5/19/59	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 McPherson ADDRESS	25. DATE RECD. BY LOCAL REG. MAY 18 '59	26. REGISTRAR'S SIGNATURE Neal Smith, M.D.
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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

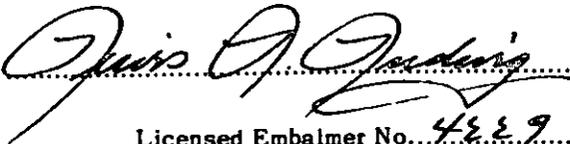
MEDICAL CERTIFICATION

S. 300
v. 1-57
15
30
1/2
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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. 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.**