

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026627

FILED VS JUL 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 6459** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>46 yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6045 Washington</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MOLLIE</b> First Middle Last <b>FINGERHOOD</b>			4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1896</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Roumania</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Ben Zweig</b>		13b. MOTHER'S MAIDEN NAME <b>Rose (unk)</b>		14. NAME OF HUSBAND OR WIFE <b>Sam</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Sam Fingerhood</b> Address <b>6045 Washington</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> <b>(non-traumatic)</b> DUE TO (b) <b>Arterio sclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <b>450.0</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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. Month, Day, Year					
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 _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i> (Degree or title)			22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>7/8/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>		23b. DATE <b>7/9/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>		23d. LOCATION (City, town, or county) (State) <b>University City, Mo.</b>
24. FUNERAL DIRECTOR <b>Berger Memorial 4715 McPherson</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>JUL 8 '59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Arvid P. Jandberg*  
Licensed Embalmer No. 4329

P. O. Address \_\_\_\_\_

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