

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027137

FILED VS AUG 3 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6715**

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 <b>St. Louis</b>			Length of stay in 1b <b>3 wks.</b>		c. CITY OR TOWN <b>University City</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7024 Tulane</b>
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle _____ Last <b>ROTHMAN</b>			4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-1890</b>	9. AGE (last birthday) <b>79</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>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Grocery</b>		11. BIRTHPLACE (City and state or country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Unk. Rothman</b>		13b. MOTHER'S MAIDEN NAME <b>Unk.</b>	
14. NAME OF HUSBAND OR WIFE <b>Eva</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>Unk.</b>	
17. INFORMANT <b>Jos. Rothman</b>		Address <b>4 Bon Price Terr.</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>Cerebral Hemorrhage</b> DUE TO (b) <b>Essential Hypertension</b> DUE TO (c) <b>331x</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
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 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 _____ 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 <b>6/26/59</b> to <b>7/17/59</b> and last saw him alive on <b>7/17/59</b> Death occurred at <b>8:50 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert Potashnick M.D.</b>		22b. ADDRESS <b>3720 Washington</b>		22c. DATE SIGNED <b>7/18/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>		23b. DATE <b>7/18/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emet</b>	
23d. LOCATION (City, town, or county) <b>University City, Mo.</b>		24. FUNERAL DIRECTOR <b>Berger Memorial 4715 McPherson</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 18 1959</b>	
26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0031- -

**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 *Quis J. Zudung*

Licensed Embalmer No. 4209

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.