

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-042540

### FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9905**

MAILED

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		c. CITY OR TOWN <b>Richmond Hgts.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp.</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7576 Clayton Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dr. Harry</b>			First			Middle			Last <b>Sorkin</b>		
4. DATE OF DEATH <b>Oct. 27th, 1959</b>			Month			Day			Year		
5. SEX <b>Male</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>1/9/14</b>		9. AGE (last birthday) <b>45</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>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chiropractic</b>				11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Simon Sorkin</b>				13b. MOTHER'S MAIDEN NAME <b>Rose Manpel</b>				14. NAME OF HUSBAND OR WIFE <b>Cylvia Sorkin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.# 2</b>				16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT Address <b>Mrs. Cylvia Sorkin 7576 Clayton Rd.</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>Hemorrhage of liver following gun shot wound</b> DUE TO (b) <b>981X</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not listed as terminal disease condition given in PART I (a) <b>Septicemia</b>						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"/>		20. MANNER OF DEATH <b>Accidental</b>		21. PLACE OF DEATH <b>Home</b>		22. DESCRIPTION OF INJURY OR CAUSE OF DEATH (See instructions in PART I, item 18.) <b>Transverse gunshot wound, 900 p.m.</b>		23. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>			
20c. TIME OF INJURY <b>900 p.m.</b>		20d. DATE OF INJURY <b>October 27, 1959</b>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>		20g. COUNTY		20h. STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ <b>9:50 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>[Signature]</i>						22b. ADDRESS <b>1300 Clark</b>			22c. DATE SIGNED <b>10/29/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10/29/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Sinai Cemetery</b>				23d. LOCATION (City, town, or county) <b>St. Louis County Missouri</b>			
24. FUNERAL DIRECTOR <b>Herman Rindskopf Inc. 5216 Delmar</b>					25. DATE RECD. BY LOCAL REG. <b>OCT 29 1959</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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affidavit imposed.

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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

*Peter B. Dubouille*

Licensed Embalmer No.

*3691*

P. O. Address

*St Louis Mo*

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.

imposed ... ..

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