

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 8 1959

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211969

STATE FILE NUMBER

Registration District No. FEB 9 Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		Length of stay in 1b 60 Years		c. CITY OR TOWN St. Louis Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosnital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 275 N. Union			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EMMA Middle LIPPMANN Last WEINSTOCK				4. DATE OF DEATH Month 12 Day 25 Year 1959			
5. SEX Female	6. COLOR OR RACE w.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11/18/73	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Herman Lippmann			13b. MOTHER'S MAIDEN NAME Jacquette Lillienfeld		14. NAME OF HUSBAND OR WIFE Walter Weinstock (Da		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.	17. INFORMANT Address Herbert Weinstock, 556 Warren			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation							INTERVAL BETWEEN ONSET AND DEATH 23 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Acute Pulmonary Edema		DUE TO (c) arterio-sclerotic heart disease		DUE TO (c) Auricular fibrillation	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200					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.) 4200					
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 Dec 1 st 1959 to Dec. 25-1959 and last saw her 12/25/59 alive on 12/25/59 Death occurred at 10 A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Herman M. Meyer M.D.				22b. ADDRESS 4409 West Pine		22c. DATE SIGNED 12/26/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12/27/59	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.		23e. ADDRESS 8400 Gravois
24. FUNERAL DIRECTOR Meyer			25. DATE RECD. BY LOCAL REG. DEC 26 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

72 X.

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 Robert M. Murr

Licensed Embalmer No. 3749

P. O. Address St Louis

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.