

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004146

EILED VS FEB 1 0 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 1122** 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>50 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>5743 Wells</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>THALLER</b> Last			4. DATE OF DEATH Month <b>Jan.</b> Day <b>31</b> Year <b>1960</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. 9-1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-------------------------	----------------------------------	---	--	-------------------------------------	---	----------------

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>USSR</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	-----------------------------------	---	---

13a. FATHER'S NAME <b>Abr. Rader</b>	13b. MOTHER'S MAIDEN NAME <b>Rebecca Thaller</b>	14. NAME OF HUSBAND OR WIFE <b>Isadore</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>Isadore Thaller</b> Address <b>5743 Wells</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>Chronic Heart Disease, Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>(?) several years</b>
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)		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 <b>for sev. years</b> and last saw her <b>relative on 1/31/60</b> Death occurred at <b>10:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>Alfred Adleshman MD</b> (Degree or title)	22b. ADDRESS <b>15 N. Brentwood</b>	22c. DATE SIGNED <b>2/1/60</b> (State)
--	--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>	23b. DATE <b>2/1/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chevra Kadisha</b>	23d. LOCATION (City, town, & county) <b>University City, Mo.</b> (State)
--	----------------------------	---	---

24. FUNERAL DIRECTOR <b>Berger Memorial</b> ADDRESS <b>4715 McPherson</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 1 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*m B.*

**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  \_\_\_\_\_

Licensed Embalmer No. 4289

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.