

FEDERAL BUREAU OF INVESTIGATION
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017871

FILED VS. MAY 6 1960

317

Primary Registration District No. 500

Registrar's No. 1446

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Westwood Village		Length of stay in 1b		c. CITY OR TOWN Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Westwood Country Club			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 818 S. Hanley			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) STANLEY GOLDMAN				First	Middle	Last	4. DATE OF DEATH Month 5 Day 1 Year 1960
5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/13/87	9. AGE (last birthday) 73	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) Retired			10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (City and state or country) Cincinnati Ohio		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME MORRIS GOLDMAN			13b. MOTHER'S MAIDEN NAME Sidonia Kline			14. NAME OF DECEASED'S WIFE Corinne M. Goldman	
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. 493-05-3754		17. INFORMANT Address Mrs. Ivan Silberman 7188 Kingsbury		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis pectoris DUE TO (b) Anteriorly located heart dis. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 9 years ?
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 Month, Day, Year 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 May 2 1952 to May 1 1960 and last saw him alive on April 12 1960 Death occurred at 9:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) Samuel B Grant M.D.				22b. ADDRESS 114 N. Taylor Ave			22c. DATE SIGNED 5/2/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/3/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai		23d. LOCATION (City, town, or county) 8400 Gravois		(State)	
24. FUNERAL DIRECTOR Mayer			ADDRESS 4356 Lindell Blvd		25. DATE RECD. BY LOCAL REG. 5-3-60	26. REGISTRAR'S SIGNATURE John B. Murphy	

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 Stanley H. Aiston

Licensed Embalmer No. 419

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.