

|  |   |   |  |   |  |  |   |                                    |  |
|--|---|---|--|---|--|--|---|------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> |  |  |   |                                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>  |   | Length of stay in 1b<br><b>1 day</b>  |  | c. CITY OR TOWN <b>University City</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |                                    |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>800 Leland</b>                       |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                    |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>IDA</b> Middle <b>DIAMOND</b> Last   |   |   |  | 4. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>9</b> Year <b>1960</b>   |  |  |   |                                    |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Unk.</b>   | 9. AGE (last birthday)<br><b>ab. 79</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HR<br>Hours Min.       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country)<br><b>Poland</b>                              |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |                                    |  |
| 13a. FATHER'S NAME<br><b>Abr. Schultz</b>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Shifra Tama</b>                                      |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Philip</b>   |   |                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT Address<br><b>Mrs. D. Rotsoff 7300 Dorset</b>                              |  |   |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO (b) _____<br>DUE TO (c) <b>4201</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cholelithiasis</b><br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |                                    |  |
| 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<br>Hour a.m. p.m.<br>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<br>COUNTY STATE  |                                    |  |
| 21. I attended the deceased from <b>Oct 1949</b> to <b>present</b> and last saw her <b>alive</b> on <b>August 9, 1960</b> .<br>Death occurred at <b>4:00 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |  |   |  |  |   |                                    |  |
| 22a. SIGNATURE (Degree or title)<br><b>Michael M. Karl MD</b>  |   |   |  | 22b. ADDRESS<br><b>Jewish Hospital</b>  |  |  |   | 22c. DATE SIGNED<br><b>8-10-60</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Rem.</b>   |   | 23b. DATE<br><b>8/11/60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chesed Shel Emeth</b>                       |   | 23d. LOCATION (City, town, or county)<br><b>University City, Mo.</b>                     |  |   | (State)                            |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Berger Memorial 4715 McPherson</b>  |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>AUG 11 1960</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Roan Smith, M.D.</b>                                 |   |                                    |  |

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 *James J. Deane*  
Licensed Embalmer No. 3988

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.