

UNITED STATES DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032865

FILED VS. SEP 2 1960 318

1003

8428

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. Registrar's No. 8428

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 checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5775 Waterman</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALEX (AKA ALEXANDER)</b> Middle <b>SIGOLOFF</b> Last				4. DATE OF DEATH Month <b>Aug.</b> Day <b>26</b> Year <b>1960</b>			
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>1/15/10</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe repairer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe repair Shop</b>		11. BIRTHPLACE (City and state or country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Unk, Sigoloff</b>			13b. MOTHER'S MAIDEN NAME <b>(unk)</b>		14. NAME OF HUSBAND OR WIFE <b>Lena</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>495-18-2449</b>		17. INFORMANT Address <b>Maurice Sigoloff 720 Interdrive</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>ACUTE TUBULAR NECROSIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) <b>181.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CARCINOMA OF BLADDER</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 AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> 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>8-16-60</b> to <b>8-26-60</b> and last saw him alive on <b>8-26-60</b> Death occurred at <b>6:30 AM</b> <b>8-26-60</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>David Berkov, M.D.</b>				22b. ADDRESS <b>Jewish Hospital</b>			22c. DATE SIGNED <b>8-26-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>		23b. DATE <b>8/28/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel E'teth</b>		23d. LOCATION (City, town, or county) <b>University City, Mo.</b>		(State)
24. FUNERAL DIRECTOR ADDRESS <b>Berger Memorial 4715 McPherson</b>				25. DATE REC'D. BY LOCAL REG. <b>AUG 27 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b>	

DOCUMENT

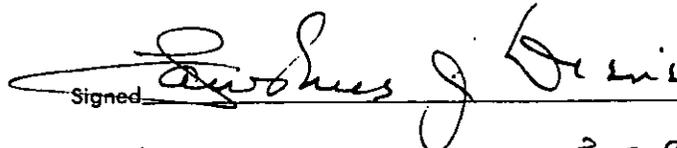
MEDICAL CERTIFICATION

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_  
Licensed Embalmer No. 398

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.