

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>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>University City</b>		Length of stay in 1b <b>3 wks.</b>	c. CITY OR TOWN <b>University City</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>608 Kingsland</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Abraham Rubanowitz</b>			4. DATE OF DEATH Month Day Year <b>Nov. 5 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (last birthday) <b>about 80</b>	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) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	11. BIRTHPLACE (City and state or country) <b>USSR</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Unk. Rubanowitz</b>		13b. MOTHER'S MAIDEN NAME <b>Unk.</b>		14. NAME OF HUSBAND OR WIFE <b>Agnes</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>Unk.</b>	17. INFORMANT Address <b>Mrs. A. Rubanowitz 608 Kingsland</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>Cardiac Asystole</b>					INTERVAL BETWEEN ONSET AND DEATH <b>0</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Auricular Flutter, Subacute</b>			<b>4 wk.</b>	
		DUE TO (c) <b>Congestive Heart Failure, chronic, resistant</b>			<b>7 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Arteriosclerosis 434.1</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 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>April 1960</b> , to <b>Nov. 5, 1960</b> and last saw her alive on <b>Nov. 4, 1960</b> Death occurred at <b>6:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree, or title) <b>Clifford R. Talbert, Jr., M.D.</b>			22b. ADDRESS <b>2165 Kingshighway</b>		22c. DATE SIGNED <b>11/5/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>11/6/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</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 RECD. BY LOCAL REG. <b>NOV 6 1960</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

