

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bernard Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4385 Maryland</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle Last <u>WOHL</u>			4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/72</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Phillip Wohl</u>		13b. MOTHER'S MAIDEN NAME <u>Lena Samisch</u>	14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>	16. SOCIAL SECURITY NO. <u>Unk.</u>	17. INFORMANT <u>Mrs. D. Wohl - 6400 Forsythe</u>	Address
---	--	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
IMMEDIATE CAUSE (a) <u>Concussion of Prostate</u>	DUE TO (b) <u>Arteriosclerotic Heart Disease</u>	<u>177x</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	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 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 <u>May 11-1959</u> to <u>Nov. 27-1960</u> and last saw him alive on <u>Nov. 25-1960</u> Death occurred at <u>11 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Herman M. Meyer M.D.</u>	(Degree or title)	22b. ADDRESS <u>4409 West Pine Blvd</u>	22c. DATE SIGNED <u>11/28/60</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11/29/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, County, Mo.</u>
---	------------------------------	---	--

24. FUNERAL DIRECTOR <u>Herman Rindskopf, Inc. 5216 Delmar</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>NOV 28 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
---	---------	--	--

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

