

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 30 1961

-61-004171

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 205 STATE FILE NUMBER

AMENDED

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manchester</u> | | c. CITY OR TOWN <u>University City, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Length of stay in 1b <u>1 week</u> | | d. STREET ADDRESS (If outside, give location) <u>811 N. McKnight</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manchester Nursing Home BARNES HOSPITAL</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>ABRAHAM</u> Middle <u>GOLD</u> Last <u>GOLD</u> | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1961</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Unk.</u> | 9. AGE (last birthday) <u>ab. 75</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | 11. BIRTHPLACE (City and state or country) <u>USSR</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Lester Gold</u> | | 13b. MOTHER'S MAIDEN NAME <u>Evelyn (unk)</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mollie</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unk.</u> | 17. INFORMANT Address <u>Harlod Gold 811 N. McKnight</u> | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebro-Vascular accidents</u> <u>4 years</u> | |
| 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 | |

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| 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 _____ e.m. _____ p.m. _____ | Month, Day, Year _____ | | |

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| 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>1956</u> to <u>death</u> and last saw <u>him</u> alive on <u>Jan. 15, 1961</u> Death occurred at <u>645 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | |

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| 22a. SIGNATURE <u>Lawrence Sale M.D.</u> (Degree or title) | 22b. ADDRESS <u>BARNES HOSPITAL 100 N. Euclid Ave.</u> | 22c. DATE SIGNED <u>1/21/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>1/22/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emet</u> |
| 23d. LOCATION (City, town, or county) (State) <u>University City, Mo. 1128</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>Berger Memorial 4715 McPherson</u> |
| 25. DATE RECD. BY LOCAL REG. <u>1-21-61</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edward J. Davis

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.