

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4956

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>2 hrs.</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		c. CITY OR TOWN <b>Clayton</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If not in institution, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>901 South Hales</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>M.</b> Last <b>ARONSON</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>24</b> Year <b>1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-1886</b>	9. AGE (last birthday) <b>74</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>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>						
13a. FATHER'S NAME <b>Rubin Brilliant</b>				13b. MOTHER'S MAIDEN NAME <b>Rachel F.</b>				14. NAME OF HUSBAND OR WIFE <b>Haskell</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Milton Aronson 6 Westridge</b> 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		
IMMEDIATE CAUSE (a) <b>myocardial infarction</b>											<b>1 hr.</b>		
DUE TO (b) <b>ARTERIOSCLEROSIS, generalized</b>											<b>Yrs.</b>		
DUE TO (c) <b>420.1 H</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 Colon - removed Aug. 1959.</b>											PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS 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 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>Jan. 55</b> to <b>MAY 61</b> and last saw her <b>him</b> alive on <b>May 24, 61</b> Death occurred at <b>3:55 pm</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Melvin R. Goldman M. D.</b>						22b. ADDRESS <b>BARNES HOSPITAL</b>				22c. DATE SIGNED <b>5/25/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)			
<b>Removal</b>		<b>5/26/1961</b>		<b>Chesed Shel Emeth</b>			<b>University City, Missouri</b>						
24. FUNERAL DIRECTOR <b>Berger Memorial 4715 McPherson Avenue</b>					25. DATE RECD. BY LOCAL REG. <b>MAY 25 1961</b>		26. REGISTRAR'S SIGNATURE <b>Lead Smith, M.D.</b>						

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

EUROPEAN AMERICAN

**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.