

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013857

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3101

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT	DOCUMENT
Rev. 4/59		
1		
2 <u>222</u>		
3		
4 <u>1</u>		
5 <u>2</u>		
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7 <u>2</u>		
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12 <u>75-0</u>		
13		
<u>75</u>	SHOULD READ	BY AFFIDAVIT OF

Joseph Babka, M.D.
USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. <u>ED MAR 21 1963</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1</u>		d. STREET ADDRESS (If outside, give location) <u>1020 Morrison</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE (AKA LILLIAN) SOLOMON</u>		4. DATE OF DEATH Month Day Year <u>3 14 63</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</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. 79</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Lithuania</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Herschel Hillkowitz</u>	
13b. MOTHER'S MAIDEN NAME <u>Ada (unk)</u>		14. NAME OF HUSBAND OR WIFE <u>Ben</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harry Solomon 6753 N. Campbell St. Chicago</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>420.1</u>			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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>3-6-63</u> to <u>3-14-63</u> and last saw her/him alive on <u>3-14-63</u> Death occurred at <u>11:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph D. Babka M.D.</u>		22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	
22c. DATE SIGNED <u>3-14-63</u>		(State)	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/17/1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chevra Kadisha</u>		23d. LOCATION (City, town, or county) <u>University City, Mo.</u>	
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 16 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>			

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



Licensed Embalmer No. 4229

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.