

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3916
Registrar's No.

FILED MAY 11 1949

1003

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. REGISTRAR'S NO.

10.300
10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO		b. COUNTY MO	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) ST. LOUIS		c. LENGTH OF STAY (In this place) 1 yr.		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5812 COTE BRILLANT AVE		d. STREET ADDRESS (If rural, give location) 5812 COTE BRILLANT AVE			
3. NAME OF DECEASED (Type or Print) a. (First) Bessie		b. (Middle) HANAH		c. (Last) Joseph	
4. DATE OF DEATH (Month) (Day) (Year) May 1, 1949		5. SEX F		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH UNKNOWN		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME MOSHA LAZER SCHNEIDER		13b. MOTHER'S MAIDEN NAME TZIVA DIVORA SMELKIN	
14. NAME OF HUSBAND OR WIFE MOTOL JOSEPH		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME Max Joseph		ADDRESS 5812 Cote Brillant			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			years
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension			years
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 92	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H43X	
22. I hereby certify that I attended the deceased from about 10:35 to 5/1, 1949, that I last saw the deceased alive on April, 1949, and that death occurred at 7:20 m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Arthur E. Straub, M.D.		23b. ADDRESS 539 N. Grand		23c. DATE SIGNED 5/1/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAY 2-49		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CO.		DATE REC'D BY LOCAL REG. 1949		25. FUNERAL DIRECTOR'S SIGNATURE Oxandoller	
REGISTRAR'S SIGNATURE J. B. Lassater		ADDRESS 5010 Enright Ave			

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
Student Embalmer

Signed W. Z. Oxend and son

Licensed Embalmer No. 3669

P. O. Address 5010 Enright Ct

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 this body is not embalmed, fact should be so stated above.