

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

No. 300  
10-48

FILED SEP 14 1949

State File No. 1003  
Registrar's No. 7709

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5895a COTE BRILLIANTE		d. STREET ADDRESS (If rural, give location) 5895a COTE BRILLIANTE	
3. NAME OF DECEASED (Type or Print) a. (First) GITTEL		c. (Last) KANTER	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH (UNKNOWN) Oct - 90	
9. AGE (In years last birthday) 47		10. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME MORRIS HERSHEL		13b. MOTHER'S MAIDEN NAME BESSIE DEBORAH (mk)	
14. NAME OF HUSBAND OR WIFE NATHAN KANTER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME MR. JACOB EHRLICH	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemiplegia, left		ANTECEDENT CAUSES		8 days	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, generalized		DUE TO (c)		years	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			

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) 91	
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? 4.500	

22. I hereby certify that I attended the deceased from April 1948, to Sept. 5, 1949, that I last saw the deceased alive on Sept. 5, 1949, and that death occurred at 2:45 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Jos. M. Orenstein, M.D.		23b. ADDRESS 4500 Olive St.		23c. DATE SIGNED 9/6/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9/6/49		24c. NAME OF CEMETERY OR CREMATORY CHESED SHEL EMETH	
24d. LOCATION (City, town, or county) UNIVERSITY CITY		(State) MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BERGER MEMORIAL 4715 MCPHERSON	

DATE REC'D BY LOCAL REG. SEP 6 1949		REGISTRAR'S SIGNATURE J. B. [Signature]	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Lewis Pulwig  
Student Embalmer No. \_\_\_\_\_

Licensed Embalmer No. 42290

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