

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32085**
Registrar's No. **8067**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 32085		Registrar's No. 8067	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) State Univ. sp.		c. LENGTH OF STAY (In this place) 45 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hosp.				d. STREET ADDRESS (If rural, give location) 1012 Franklin					
3. NAME OF DECEASED (Type or Print) a. (First) JACOB c. (Last) PETTRICK		AKA (PETRICK, and off) AKA PETUCKOFF		4. DATE OF DEATH (Month) (Day) (Year) Sept. 17, 1949					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never married		8. DATE OF BIRTH Unk		9. AGE (In years last birthday) ab 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Men's wear		11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Abraham			13b. MOTHER'S MAIDEN NAME Esther Arloff			14. NAME OF HUSBAND OR WIFE _____			
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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Dorothy Sanders 920 Eastgate					
18. CAUSE OF DEATH State only on certificate per §§ 190.01, 190.02 and (c) <i>This does not mean the mode of dying, such as heart failure, pneumonia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 hrs. ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) Hypertensive cardio vascular disease 6mosx DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>							
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) 920					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X					
22. I hereby certify that I attended the deceased from Mar. 21, 1949 , to Sept. 17, 1949 , that I last saw the deceased alive on Sept. 17, 1949 , and that death occurred at 6.20a m. , from the causes and on the date stated above.									
23a. SIGNATURE Paul T. Hartman M.D.				23b. ADDRESS 5400 Arsenal St.				23c. DATE SIGNED 9/17/49	
24a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		24b. DATE 9/19/49		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel meth		24d. LOCATION (City, town, or county) (State) University City Mo			
DATE REC'D BY LOCAL SEP 19 1949		REGISTRAR'S SIGNATURE J. C. Laente			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson				

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Lewis L Ludwig*

Licensed Embalmer No. *9229 F*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State of Missouri
City of St. Louis } ss.

State File No. 32085
Local Registrar's No. 8067

AFFIDAVIT FOR CORRECTION OF A RECORD

On this 27th day of September, 1949, before me appears

Mrs. Dorothy Sanders, who, upon her oath, states that the original record of ~~XXX~~ death for Jacob Petuckoff aka Petrick died ~~XXXX~~ September 17, 1949, in the State of Missouri, and which was filed at St. Louis on Sept 1949, should be corrected as follows:

Item No. 3 should read Jacob Pettrick (aka Petrick and Petuckoff)

Instead of Jacob Petuckoff (aka Petrick)

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant Mrs Dorothy Sanders sister
Relationship.

920 Eastgate

Present Address

University City, Mo.

Subscribed and sworn to before me this 27th day of September, 1949.

My Commission Expires June 8, 1951

[Signature]
Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

