

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **35020**  
8775  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>35020</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>20 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>44 Clayton</b>		442	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>7418 Byron</b>			
3. NAME OF DECEASED a. (First) <b>FANNIE LADINSKY</b>		b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 14, 1950</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>Unknown</b>	
9. AGE (In years last birthday) <b>Abt. 84</b>		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) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>4</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Wolf Ladinsky</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Louis Schwartz-7418 Byron</b> ADDRESS _____			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>				INTERVAL BETWEEN ONSET AND DEATH <b>20-DAYS</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis Generalized</b>					
		DUE TO (c) _____					
		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) _____			
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? <b>H20!</b>			
22. I hereby certify that I attended the deceased from <b>Feb</b> , 1946, to <b>Oct. 14, 1950</b> , that I last saw the deceased alive on <b>Oct 14</b> , 1950, and that death occurred at <b>7-30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Roy Greenbaum M.D.</b> (Degree or title)				23b. ADDRESS <b>508 W. Grand</b>		23c. DATE SIGNED <b>10/15/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10/16/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>OCT 17 1950</b>		REGISTRAR'S SIGNATURE <b>L. B. Pasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Norman Bruderski, Inc. 5216 Delmar</b> ADDRESS _____			

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 Embalmer No.....

Signed.....  
Student Embalmer

Signed

*John Ketter*  
Licensed Embalmer No. 3880  
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.