

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38926
9493
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis
c. LENGTH OF STAY (In this place) _____
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129
d. STREET ADDRESS (If rural, give location) 5055 Cabanne Ave. 0

3. NAME OF DECEASED
a. (First) THEODORE b. (Middle) _____ c. (Last) POKRES

4. DATE OF DEATH (Month) (Day) (Year)
Nov. 6, 1950

5. SEX Male 0 6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /

8. DATE OF BIRTH Unknown

9. AGE (In years last birthday) Months Days Hours Min. Aht. 68

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber

10b. KIND OF BUSINESS OR INDUSTRY Plumbing

11. BIRTHPLACE (State or foreign country) Russia 6

12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Morris Pokres

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Gertrude Pokres

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. G. Pokres-5055 Cabanne

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 8 hours
?

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) m. _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 232X

22. I hereby certify that I attended the deceased from 1-10, 1940, to 11-6, 1950; that I last saw the deceased alive on 11-6, 1950, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Melvin B. Kratochvil MD

23b. ADDRESS 607 N. Grand Ave.

23c. DATE SIGNED 11-7-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/8/50

24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem. St. Louis, Mo.

24d. LOCATION (City, town, or county) (State) _____

DATE REC'D BY LOCAL REG. NOV 8 1950

REGISTRAR'S SIGNATURE J. B. Sauter

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS _____

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 Embalmer No.

Signed _____

John Kettes
Licensed Embalmer No. 3880

Signed.....
Student Embalmer

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.