

FILED DEC 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43134

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 2002 Registrar's No. 3006

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>University City</u>	c. LENGTH OF STAY (In this place) <u>7 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>33 TOWN University City 4336</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6409 Enright Ave.</u>		d. STREET ADDRESS (If rural, give location) <u>6409 Enright Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Rose</u> b. (Middle) _____ c. (Last) <u>Greenblatt</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 12, 1950</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>Ab. 66</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Russia 6</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Jacob Hirsch</u>		13b. MOTHER'S MAIDEN NAME <u>Anna (unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Max Greenblatt</u>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Max Greenblatt 6409 Enright Ave.</u>			
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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) <u>Myocarditis chronic</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> II. OTHER SIGNIFICANT CONDITIONS <u>Anteroseclerosis</u> Conditions contributing to the death but not related to the disease or condition causing death. DUE TO (b) _____ DUE TO (c) _____		
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19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) <u>4321</u>		
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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? _____		
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22. I hereby certify that I attended the deceased from Nov. 10, 1950, to Dec. 12, 1950, that I last saw the deceased alive on 12/12, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. W. C. Freeman, M.D.</u>		23b. ADDRESS <u>462 No. Joylor</u>		23c. DATE SIGNED <u>12/13/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12/13/1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Beth Ham Hag.</u>	24d. LOCATION (City, town, or county) (State) <u>Clayton Missouri</u>	
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DATE REC'D BY LOCAL REG. <u>12-13-50</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Berger Memorial 4715 McPherson Ave.</u>		
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RWR (Licensed Embalmer's Statement on Reverse Side)

**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.....

*Quiro A. Prudwig*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4829*.....

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.**