

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31447**

FILED OCT 10 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8260**

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

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) ST. LOUIS		c. LENGTH OF STAY (In this place) 37 yrs	c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		2069
d. FULL NAME OF HOSPITAL OR INSTITUTION JOWISA Hosp.			d. STREET ADDRESS (If rural, give location) 6 1410th Shawmut		
3. NAME OF DECEASED (Type or Print) a. (First) Nettie		b. (Middle)	c. (Last) FINBUND	4. DATE OF DEATH (Month) (Day) (Year) Sept 18 1951	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan 25 1892	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) USSR b		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Jos Gitlin		13b. MOTHER'S MAIDEN NAME BRINDA LEVIN	14. NAME OF HUSBAND OR WIFE ZACHARIA		
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. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS ZACHARIA FINBUND 1416th SHAWMUT		
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism renal embolism arterio-sclerotic heart disease cardiac failure. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerotic heart disease cardiac failure. 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
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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H200			
22. I hereby certify that I attended the deceased from 9/28/1951 , to 9/18/1951 , that I last saw the deceased alive on 9/17 , 1951, and that death occurred at 2:55 am. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Robert Datschick M.D.		23b. ADDRESS 508 N. Grand Ave.		23c. DATE SIGNED 9/18/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) buried	24b. DATE 9/19/51	24c. NAME OF CEMETERY OR CREMATORY Grand St. Smith	24d. LOCATION (City, town, or county) (State) University City Mo		
DATE REC'D BY LOCAL REG. SEP 18 1951		REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alger Memorial 2715 McPheason		

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 _____

Licensed Embalmer No. 4194

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.