

FILED NOV 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35345

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9551

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kentucky</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Saint Louis</u>		c. LENGTH OF STAY (in this place) <u>8 wks.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bernard Nursing Home</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mayfield</u>	
		d. STREET ADDRESS (If rural, give location) <u>615 South 6th Street</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) c. (Last) <u>Lookofsky</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 29, 1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>Ab. 62</u>		IF UNDER 1 YEAR Months Days	IF UNDER 18 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Unknown Goodman</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Joseph Lookofsky</u>
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>Louis Lookofsky, Mayfield, Ky.</u>
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) <u>Cerebral Thrombosis, etc.</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerosis, general</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Ca of Colon (Resected)</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>332XH</u>	
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?
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>49</u> , to <u>Oct</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Oct 28</u> , 19 <u>51</u> , and that death occurred at <u>9 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Burton A. Stutz</u>		23b. ADDRESS <u>H.P.O. 457 N. Humphreys</u>	23c. DATE SIGNED <u>10/29/51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10/27/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Temple Israel Cem.</u>
24d. LOCATION (City, town, or county) (State) <u>Paducah, Kentucky</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Berger Memorial 4715 McPherson Ave.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 2 1952

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 *James J. Anderson*

Licensed Embalmer No. *4 E 29*

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.