

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

3211

FILED JAN 26 1952

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 0446

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo.		
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 12 yrs.	c. CITY OR TOWN St. Louis		2139
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital			d. STREET ADDRESS 5400 Arsenal St.		
3. NAME OF DECEASED (Type or Print) SARAH			a. (First)	b. (Middle)	c. (Last) POLLACK
4. DATE OF DEATH Jan. 14, 1952			4. DATE (Month) (Day) (Year)		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 8 - 1894	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months
IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USSR	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Herman Klayman		13b. MOTHER'S MAIDEN NAME Dora Unk		14. NAME OF HUSBAND OR WIFE Ben	
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 Ben Pollack 1480 Burd	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Parotid			INTERVAL BETWEEN ONSET AND DEATH 1 yr x		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.					
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? 142.1			
22. I hereby certify that I attended the deceased from Jan. 1, 1951, to Jan. 14, 1952, that I last saw the deceased alive on Jan. 14, 1952, and that death occurred at 9:45p m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Cecilia A. ... MD			23b. ADDRESS 5400 Arsenal St.		23c. DATE SIGNED 1/14/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1/16/52	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel		24d. LOCATION (City, town, or county) (State) University City	
DATE RECD BY LOCAL REG. JAN 15 1952	REGISTRAR'S SIGNATURE J. Earl Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial 4715 McPherson			

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Lewis L. Ludwig*

Licensed Embalmer No. 9229

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.