

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

10476

State File No.

FILED APR 12 1952

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2636	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2249			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL				d. STREET ADDRESS (If rural, give location) 2835 OSAGE			
3. NAME OF DECEASED (Type or Print), BARBARA C. REZNICK			a. (First)	b. (Middle)	c. (Last) Reznick	4. DATE OF DEATH (Month) (Day) (Year) MAR. 19 1952	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH OCT. 4 1880		9. AGE (In years has birthday) 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and State or Foreign Country) MISSOURI U		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME JOHN SLAIS		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE WILLIAM REZNICK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS WILLIAM REZNICK 2835 OSAGE			
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) Fr of Skull; Brain Injury ANTECEDENT CAUSES They deceased fell down due to steps from porch to ground about at about 11:25 am DUE TO (c) on Mar 11, 1952 at his home II. OTHER SIGNIFICANT CONDITIONS 2835 Osage St 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 Accident				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) Stroke Accident		21b. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Mar 11 5:11 AM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 9000-21			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:51 p.m., from the causes and on the date stated above.							
23a. SIGNATURE Samuel E Taylor				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 3.20.52	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE MAR 27 1952		24c. NAME OF CEMETERY OR CREMATORY RESURRECTION		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL MAR 20 1952		REGISTRAR'S SIGNATURE J. Call Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Grannis			

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 _____

Samuel Hill

Licensed Embalmer No. _____

4347

P. O. Address _____

2906 Illinois

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.