

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33518

FILED OCT 11 1952

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1003

State File No.

8947

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) <u>7 4524</u>		d. STREET ADDRESS (If rural, give location) <u>2023 Big Bend</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>JEWISH HOSPITAL</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>GEORGE</u>		b. (Middle) <u>G.</u>	c. (Last) <u>UNGAR</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 24 52</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct 10 1891</u>	9. AGE (in years last birthday) <u>60</u>	10. MONTHS <u>11</u> DAYS <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Samuel Ungar</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Loewenstein</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Ungar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>1918 To 1921</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Margaret Ungar</u> ADDRESS <u>2023 Big Bend</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>Coronary occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u> <u>years</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? <u>4201</u>			
22. I hereby certify that I attended the deceased from <u>8/3</u> , 19 <u>46</u> , to <u>9/24</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>9/24</u> , 19 <u>52</u> , and that death occurred at <u>10 A.</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Walter Franklin M.D.</u> (Degree or title)			23b. ADDRESS <u>6342 Grand</u>		23c. DATE SIGNED <u>9/25/52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>SEPT 26-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
DATE REC'D BY LOCAL SEP 25 1952		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman Rindshoff Inc. 5316 - Delmar</u> ADDRESS _____	

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

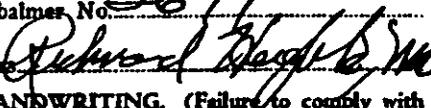
Signed



Licensed Embalmer No.

3691

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.