

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45084

State File No. \_\_\_\_\_

FILED JAN 26 1953

318

REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. 1003 Registrar's No. 11924

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>48 yrs.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5820 Julian</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>LENA</u> b. (Middle) c. (Last) <u>SINGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 26, 1952</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</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 12 MRS. Hours _____ Mins. _____
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	11. BIRTHPLACE (City and State or Foreign Country) <u>USSR 6</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Nathan Schechter</u>	
13b. MOTHER'S MAIDEN NAME <u>Edith Unk.</u>		14. NAME OF HUSBAND OR WIFE <u>Mike</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 <u>Mike Singer</u>		ADDRESS <u>5820 Julian</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 hemorrhage with a recent cerebral embolus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Fracture</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis cerebral</u>		years	
DUE TO (c) <u>art. encephaloma, large art. Rt. heart, plegia (old),</u>		" <u>one year</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>cardiac arrhythmia</u>		4 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>334X</u>			
22. I hereby certify that I attended the deceased from <u>Oct. 15, 1948</u> , to <u>Dec. 26, 1952</u> , that I last saw the deceased alive on <u>Dec. 26, 1952</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Shirley Dale M.D.</u>		23b. ADDRESS <u>4500 Olive</u>	
23c. DATE SIGNED <u>12/26/52</u>			
24a. BURIAL (CREMATION, REMOVAL) <u>Removal</u>		24b. DATE <u>12/28/52</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel meth Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>University City Mo.</u>	
DATE REC'D BY LOCAL REG <u>DEC 27 1952</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Berger Memorial</u>		ADDRESS <u>4715 McPherson</u>	

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

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**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 \_\_\_\_\_

*John A. Auding*

Licensed Embalmer No. 4229

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.