

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23179

FILED JUN 20 1953

State File No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5411

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <u>1224a Shawmut Pl.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1224a Shawmut Pl.</u>		d. STREET ADDRESS <u>1224a Shawmut Pl.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Rose</u> b. (Middle) c. (Last) <u>Tabachnik</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5 30 53</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>71</u>	# UNDER 1 YEAR # UNDER 24 HRS. Days 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		11. BIRTHPLACE (City and State or Foreign Country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Abe Tabachnik</u>
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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.	17. INFORMANT'S SIGNATURE OR NAME <u>Sam Chazen</u>	ADDRESS <u>1224 Shawmut Pl.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Cardiovascular Disease</u>		DUPLICATE TO (b) _____		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE TO (c) _____		
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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4200</u>
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22. I hereby certify that I attended the deceased from Sep. 5/30, 1952 to 5/30, 1953, that I last saw the deceased alive on 5/30, 1953, and that death occurred at 4:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Thomas Oehl M.D.</u>	(Degree or title)	23b. ADDRESS <u>601 Humboldt Bldg</u>	23c. DATE SIGNED <u>5/30/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5-31-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>JUN 1 1953</u> <u>J. Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>HERMAN RINDSKOPF, INC., 5216 DELMAR</u>	ADDRESS
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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

Not Embalmed
John Ketter

Licensed Embalmer No. 3880

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform to the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.