

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

STANDARD CERTIFICATE OF DEATH

FILED JAN 26 1954

State File No. **3000**
 Registrar's No. **0225**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY 4		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE California b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Hollywood 8040	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bernard Nursing Home		d. STREET ADDRESS (If rural, give location) 813 N. McCadden 8	
3. NAME OF DECEASED (Type or Print) SARAH		4. DATE OF DEATH (Month) (Day) (Year) January-9-1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) abt-72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (City and State or Foreign Country) Russia 6	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Ephraim Benner	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Jacob Landau	
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. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Mrs. F. Kling-25 Westwood		ADDRESS Club House	
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) Coronary thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. gangrene of left leg	
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 4201		22. I hereby certify that I attended the deceased from Oct , 19 52 , to 11/9 , 19 54 , that I last saw the deceased alive on 11/8 , 19 54 , and that death occurred at 5 A.m. , from the causes and on the date stated above.	
23a. SIGNATURE Carl Rindskopf M.D.		23b. ADDRESS 634 N. 4th	
23c. DATE SIGNED 1/8/54		24. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 1/10/54		24c. NAME OF CEMETERY OR CREMATORY Los Angeles, Calif.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Herman Rindskopf, Inc., 5216 Delmar	
DATE REC'D BY LOCAL REG. JAN 11 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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 Ketter

Licensed Embalmer No. 3880

P. O. Address St. Louis, Mo.

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.