

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7036**

BIRTH NO. **FILED MAR 4 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1036**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 5100 Arsenal St.	
3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) c. (Last) ZAX		4. DATE OF DEATH (Month) (Day) (Year) Jan. 28, 1954.	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 4/22/83
9. AGE (In years last birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	11. BIRTHPLACE (City and State or Foreign Country) Hungary	12. CITIZEN OF WHAT COUNTRY? Hungary
13a. FATHER'S NAME Joseph Sax	13b. MOTHER'S MAIDEN NAME Mary Saxie	14. NAME OF HUSBAND OR WIFE Michael Zax	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Ma. Behar 2331 Mullophy	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES DUE TO (b) Generalized broncho-pneumonia DUE 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 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? 4201	
22. I hereby certify that I attended the deceased from Jan. 1, 1952 , to Jan. 28, 1954 , that I last saw the deceased alive on Jan. 28, 1954 and that death occurred at 2:15p. m. , from the causes and on the date stated above.			
23a. SIGNATURE Bette Harris Simon, M.D.	(Degree or title)	23b. ADDRESS 5100 Arsenal St.	23c. DATE SIGNED 1/30/54
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB-3-54	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST LOUIS MO
DATE REC'D BY LOCAL REG. FEB 2 1954	REGISTRAR'S SIGNATURE J. Cash Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Cullen Kelly ADDRESS 4386 Lindell	

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

(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.....
Signature of Student Embalmer

Signed *Frank O. Merrick*

Licensed Embalmer No. *485*

P. O. Address *St Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.