

FILED FEB 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **43913**No. 300  
10.48BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11781**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		a. STATE <b>Mo.</b>	b. COUNTY <b>St. Louis</b>
c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>University City</b>	d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
d. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION: <b>Jewis h Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>6318 Cabanne</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>LENA</b>	b. (Middle)	c. (Last) <b>POLINSKY</b>	(Month) <b>Dec.</b>	(Day) <b>27</b>	(Year) <b>1954</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid.</b>	8. DATE OF BIRTH <b>Jan. 17, 1871</b>		9. AGE (In years last birthday) <b>83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>USSR</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Aaron Pa dratzik</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah--</b>	14. NAME OF HUSBAND OR WIFE <b>Louis</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Pearl Block</b>
		ADDRESS <b>7301 Delmar</b>

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>  <b>years</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>cerebral arteriosclerosis</b> 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 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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>331x</b>

22. I hereby certify that I attended the deceased from **Dec 18, 1954**, to **Dec 27, 1954**, that I last saw the deceased alive on **Dec 26**, 1954, and that death occurred at **7 A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Frank Cohen</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>5899 Delmar St. St. Louis, Mo.</b>	23c. DATE SIGNED <b>12-27-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>	24b. DATE <b>12/28/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Beth Ham Hagodol</b>	24d. LOCATION (City, town, or county) (State) <b>Ladue, Mo.</b>

DATE REC'D BY LOCAL REG. <b>DEC 27 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Berger Memorial</b>	ADDRESS <b>4715 McPherson</b>
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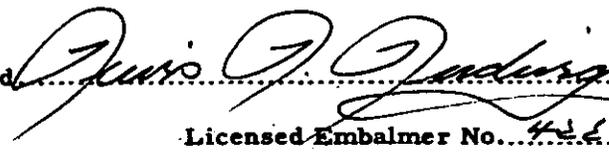
(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed  .....  
Licensed Embalmer No. ....

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