

FILED JAN 30 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 1226  
Registrar's No. 39

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>39</u>					
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Arkansas</u> b. COUNTY <u>Fulton</u>							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (in this place) <u>6 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Salem</u>		d. STREET ADDRESS (If rural, give location) <u>2303</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christi Hogan Hospital</u>				d. STREET ADDRESS (If rural, give location)							
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX					
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)	Female	6. COLOR OR RACE				
<u>MARIE</u>	<u>GLUSHITSKY</u>	<u>ALEXANDER</u>	Jan.	21,	1956	White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)				
8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 6 HRS.	IF UNDER 1 MIN.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)				
Jan. 1, 1875	81	Months	Days	Hours	Domestic	Home	Vladimir, Russia				
12. CITIZEN OF WHAT COUNTRY?	13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE	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	ADDRESS				
None	Alexander Alexandrovski	Barbara Kishkin	Glushitsky Alexander	No	None	Boris G. Alexander	Des Moines, Iowa				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u>				DUE TO (b) <u>Arterial sclerosis</u>				1 week			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				DUE TO (c) _____				12 years			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				332X							
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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
								21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/16/56</u> , 19 <u>56</u> , to <u>1/21/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/21/56</u> , 19 <u>56</u> , and that death occurred at <u>10:24 P.M.</u> , from the causes and on the date stated above.											
23a. SIGNATURE (Degree of title) <u>C. Callahan M.D.</u>				23b. ADDRESS <u>West Plains, Mo</u>				23c. DATE SIGNED <u>1-24-56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)					
Burial		1/25/56		Salem Cemetery		Salem, Arkansas					
DATE REC'D BY LOCAL REG. <u>1-27-56</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		379		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Carter Funeral Service Salem, Ark.</u>					

(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 .....  
Student Embalmer

Signed Leland Carter

Licensed Embalmer No. 45-16

P. O. Address Shaver, 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.