Health Welfare Public Service

300 4
1-56

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 6721

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 874

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Nursing Home — Length of stay in 1b 6 mths

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Clayton — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 745 Glenridge — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ZLATA Middle Last WALDMAN
4. DATE OF DEATH Month Day Year Jan. 27, 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Unk.
9. AGE (In years last birthday) ab. 97
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) USSR
12. CITIZEN OF WHAT COUNTRY? USSR
13. FATHER'S NAME Michael Chazen
14. MOTHER'S MAIDEN NAME Unk.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Jennie Grossman — Address 745 Glenridge

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis - general
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.0
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ O
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 1946 to 1-27-57 and last saw her him alive on 1-27-57
Death occurred at 11:25 AM m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Edward J. Berger (Degree or title) MD O
22b. ADDRESS 457 N. Kingshighway
22c. DATE SIGNED 1-28-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.
23b. DATE 1/29/57
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth
23d. LOCATION (City, town, or county) University City, Mo. (State)
24. FUNERAL DIRECTOR Berger Memorial ADDRESS 4715 McPherson
25. DATE RECD. BY LOCAL REG. JAN 28 '57
26. REGISTRAR'S SIGNATURE Earl Smith MD

(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 en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 42

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.