

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15396**
3715
Registrar's No.

FILED MAY 6 - 1957

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3715					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital				e. STREET ADDRESS (If rural, give location) City Infirmery 5800 Arsenal St.							
3. NAME OF DECEASED (Type or Print) Herman			a. (First)		b. (Middle)		c. (Last) Ungar				
4. DATE OF DEATH (Month) (Day) (Year) April 17, 1957		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH Jan. 10, 1883			
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 WKS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY _____			13a. FATHER'S NAME Carl Ungar		13b. MOTHER'S MAIDEN NAME Rosa Block			
13c. NAME OF HUSBAND OR WIFE Rose		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Hospital Records			ADDRESS 5800 Arsenal St.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) General paresis of the insane				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) General paresis of the insane				INTERVAL BETWEEN ONSET AND DEATH 20 yrs.			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 025x							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis				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? _____							
22. I hereby certify that I attended the deceased from 8-26 , 19 40 , to 4-17 , 19 57 , that I last saw the deceased alive on 4-17 , 1957, and that death occurred at 2:05p. m. , from the causes and on the date stated above.											
23a. SIGNATURE (Name or title) D. K. Rindkopf M.D.				23b. ADDRESS 5400 Arsenal Street				23c. DATE SIGNED 4-18-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. NAME OF CEMETERY OR CREMATORY Mt. Sinai		24c. LOCATION (City, town, or county) St. Louis Co., Mo.		(State) _____					
DATE REC'D BY LOCAL REG. APR 18 '57		REGISTRAR'S SIGNATURE J. Carl Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE Herman Rindkopf, Inc.		ADDRESS 5216 Delmar Blvd.					

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 *Peter P. Dubrovnik*.....

Licensed Embalmer No. *3691*.....

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.