

FILED DEC 9 - 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 10723  
Registrar's No. 10723

Registration District No. 318 Primary Registration District No. 1003

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY - OR TOWN University City		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 14 Jewish Hosp.			Length of stay in 1b 2 days 27		d. STREET ADDRESS (If outside, give location) 6284 Cates		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last HYMAN Schrier SCHRIER				4. DATE OF DEATH Month Day Year 11 - 10 - 57					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1892		9. AGE (In years birthdays) 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser			10b. KIND OF BUSINESS OR INDUSTRY Wom. Garm. Manf.		11. BIRTHPLACE (City and state or country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Jacob Schrier			13b. MOTHER'S MAIDEN NAME Shirley (unk)			14. NAME OF HUSBAND OR WIFE Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 97-03-2265		17. INFORMANT Address Rose Schrier 6284 Cates				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma carcinoma of esophagus</u> DUE TO (b) <u>carcinoma Esophagus</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) 150X							INTERVAL BETWEEN ONSET AND DEATH 18 mos. 2 yrs.		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>1955</u> to <u>Nov 10, 1957</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>11-9-57</u> Death occurred at <u>12:25 AM - 12:25 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Melvin B. Kirshen</u> (Name or title) M.D.				22b. ADDRESS <u>607 N. Grand</u>				22c. DATE SIGNED <u>11-10-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u>		23b. DATE <u>11/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>			23d. LOCATION (City, town, or county) (State) <u>University City Mo.</u>			
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u>				25. DATE RECD. BY LOCAL REG. <u>NOV 12 57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> m 80.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

St. Louis University City of St. Louis  
 Joseph Schrier  
 Nov. 15, 1893  
 Rose Schrier (wife)  
 427-03-2265  
 Rose Schrier 628A Gates

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 *Joseph Schrier*  
 Licensed Embalmer No. *2988*

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.

Better Memorial Park