Health, Welfare Public Service

300
1-57

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

46537
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 3018

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN University City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6263 Cabanne — Length of stay in 1b: 18 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN University City #336 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 6263 Cabanne — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First ROSE Middle Last WISHNE
4. DATE OF DEATH Month Day Year Nov. 29, 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH Jan. 25, 1873
9. AGE (In years last birthday) 84 — 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 At home
11. BIRTHPLACE (City and state or country) Russia
12. CITIZEN OF WHAT COUNTRY? Russia
13a. FATHER'S NAME Albert Roll
13b. MOTHER'S MAIDEN NAME Faiga (unk)
14. NAME OF HUSBAND OR WIFE Julius
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. S. Block Address 6801 Crest

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — chronic
DUE TO (c) 4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

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 July 20, 1950 to November 29, 57 and last saw her alive on Nov 29, 1957
Death occurred at 6:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Tom Chamos (Degree or title) MD
22b. ADDRESS 634 N. Grand
22c. DATE SIGNED 11/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12/1/57
23c. NAME OF CEMETERY OR CREMATORY Beth H amedrosh Hagodol
23d. LOCATION (City, town, or county) (State) Ladue, Mo.

24. FUNERAL DIRECTOR Berger Memorial ADDRESS 4715 McPherson
25. DATE RECD. BY LOCAL REG. 12-1-57
26. REGISTRAR'S SIGNATURE Herbert R Donkel MD

(Licensed Embalmer's Statement on Reverse Side)

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.

acc

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. 3988

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.