

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015830
STATE FILE NUMBER

FILED APR 28 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4091**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hosp.		d. STREET ADDRESS (If outside, give location) 7236 Balson	
3. NAME OF DECEASED (Type or print) SARAH GLASSER		4. DATE OF DEATH April 14, 1958	
5. SEX Female	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 April 1, 1902
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) St. Louis, Mo.
13a. FATHER'S NAME Meyer Holtzman		13b. MOTHER'S MAIDEN NAME Ida Seidel	14. NAME OF HUSBAND OR WIFE Hyman
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. None	17. INFORMANT Address Hyman Glasser 7236 Balson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) chronic interstitial nephritis DUE TO (c) General arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
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 a.m. p.m. —		20d. INJURY OCCURRED WHILE AT WORK <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 4-1-58 to 4-14-58 and last saw her alive on 4-14-58 . Death occurred at 2:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. Fuchs, M.D. (Degree or title)		22b. ADDRESS 608 Highland	
22c. DATE SIGNED 4-14-58		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		23b. DATE 4/15/58	
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		23d. LOCATION (City, town, or county) (State) University City, Mo.	
24. FUNERAL DIRECTOR Berger Memorial		25. DATE RECD. BY LOCAL REG. APR 15 58	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		26. REGISTRAR'S SIGNATURE m. j. B	

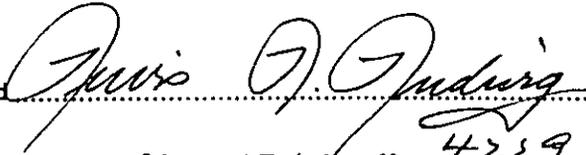
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. 4229
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.