

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023703  
STATE FILE NUMBER

FILED JUN 27 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6335

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, give TOWNSHIP only) Inside Limits OR St. Louis Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR 5316 Pershing Ave. 1/27		STREET (If outside, give location) Reside on Farm ADDRESS 5316 Pershing Ave. Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MOLLIE GROSS RUSSACK			4. DATE OF DEATH Month Day Year JUNE 21st 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1879 79
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	9b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Austria	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Bernard Gross		14. MOTHER'S MAIDEN NAME Hannah Kopp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) UNK.	16. SOCIAL SECURITY NO. UNK.	17. INFORMANT Address Morton Russack-5316 Pershing Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Accident</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>331X</i>			INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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 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 <i>1930</i> to <i>Present</i> and last saw <i>her</i> alive on <i>6-19-58</i> Death occurred at <i>3P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>M. H. O.</i> (Degree or title)		22b. ADDRESS <i>4500 Olive</i>	22c. DATE SIGNED <i>6-23-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<i>Removal</i>	<i>6/23/58</i>	<i>Mt. Olive Cemetery</i>	<i>St. Louis County Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>Herman Rindskopf Inc. 5216 Delmar</i>		25. DATE RECD. BY LOCAL REG. <i>JUN 23 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>

Health, & Welfare Public Service  
300 1-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
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

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Philip DeHirind*

Licensed Embalmer No: 369

P. O. Address *J. H. ...*

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