

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031295

STATE FILE NUMBER

AUG 18 1958

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2082

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Brooklyn</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Hgts.</b>		c. CITY OR TOWN <b>Brooklyn</b> <b>8310 4</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>400 NEW LOTS AVE</b>	

3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>OSTRINSKY</b> Last <b>OSTRINSKY</b>			4. DATE OF DEATH Month <b>AUG.</b> Day <b>9</b> Year <b>1958</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 9, 1884</b>	9. AGE (In years, months, days) <b>74</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b>	IF UNDER 24 HRS. Hours <b>14</b> Min. <b>14</b>
10a. USUAL OCCUPATION (Give kind of work done during above period, or when retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PAINT</b>		11. BIRTHPLACE (City and state or country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>UNK.</b>		13b. MOTHER'S MAIDEN NAME <b>UNK.</b>		14. NAME OF HUSBAND OR WIFE <b>BESSIE OSTRINSKY</b>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) <b>UNK.</b>		16. SOCIAL SECURITY NO. <b>UNK.</b>		17. INFORMANT Address <b>LAWRENCE OSHINS 1110 MONA DR</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asthma, Chronic Bronchial</b>			INTERVAL BETWEEN ONSET AND DEATH <b>30 years.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Myocardial Infarction</b>			<b>3 months.</b>
	DUE TO (c) <b>Cardiac De compensation - arteriosclerotic</b>			<b>10 days.</b>
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"/>	

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.) <b>241X</b>		
20c. TIME OF INJURY Hour <b>7:30</b> Month, Day, Year <b>July 1958</b>			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		

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 <b>July 1958</b> to <b>Aug 9 1958</b> and last saw <sup>her</sup> him alive on <b>Aug 9 1958</b> Death occurred at <b>7:30 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Sheldon Freedman M.D.</b>			22b. ADDRESS <b>607 No. Grand Blvd</b>		22c. DATE SIGNED <b>8/10/58</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>8/10/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. HERBON CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>FLUSHING N.Y.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>HERMAN RUDSKOPF-INC. 5216 DELMAR</b>		25. DATE RECD. BY LOCAL REG. <b>8-10-58</b>	26. REGISTRAR'S SIGNATURE <b>Wesley R. Dornick M.D.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

social conditions, etc. may use any standard nomenclature in item 18. No symptoms will be listed. 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 *Auto B Dubouille* .....

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

P. O. Address *Stamper* .....

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.