

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019525

STATE FILE NUMBER

Registration District No. 4419

FILED MAY 22 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. 4419

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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) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hosp		d. STREET ADDRESS (If outside, give location) 5400 Arsenal	
3. NAME OF DECEASED (Type or print) First Middle Last IDA PLAX		4. DATE OF DEATH Month Day Year May 5, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) Ab. 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Russia
12. CITIZEN OF WHAT COUNTRY? Russia		13. FATHER'S NAME Joseph Plax	
14. MOTHER'S MAIDEN NAME Hannah Unknown		15. NAME OF HUSBAND OR WIFE -----	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, NO unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. None	18. INFORMANT Address Chas. Plax 7838 Blackberry
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Right Hip</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arterio sclerosis</i> DUE TO (c) <i>E 904.7 45</i>			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter only one cause in PART I or PART II, Section 18.) <i>Slipped in fall at Saint Louis State Hospital.</i>		
20c. TIME OF INJURY Hour Month, Day, Year 4:55 p.m. April 5, 1959	20d. PLACE OF INJURY (e.g., in or about home, farm, shop, street, office bldg., etc.) 31 Hospital		
20e. CITY, TOWN, OR LOCATION St. Louis Mo	20f. COUNTY STATE		
21. I attended the deceased from <i>550</i> to <i>AP</i> and last saw her alive on <i>AP</i> Death occurred at <i>AP</i> on the date stated above; and to the best of my knowledge, from the causes stated			
22a. SIGNATURE (Do not write in ink) <i>Joseph In Zuehl</i>		22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>5/5/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/6/1959	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	23d. LOCATION (City, town, or county) (State) University City, Missouri
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson Ave.		25. DATE RECD. BY LOCAL REG. MAY 5 '59	26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

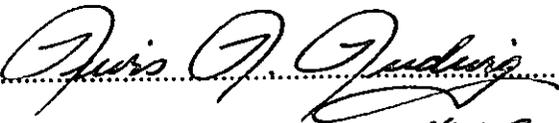
All diseases in Part I must be causally related.

No symptoms were ascribed.

**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.**