

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003416

FILED VS FEB 1 0 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's **R 1137** STATE FILE NUMBER

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	Length of stay in 1b	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) HOSPITAL OR INSTITUTION Bernard Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 108 N. Kingshighway Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First C. Middle LEW Last GALLANT			4. DATE OF DEATH Month January Day 31 Year 1960			
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5. SEX Male	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 8/14/81	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Latvia	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Abraham I. Gallant	13b. MOTHER'S MAIDEN NAME Zelda Kaplan	14. NAME OF HUSBAND OR WIFE
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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. Unk.	17. INFORMANT Max Gallant-902 N. Kingshighway Address
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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) Lymphosarcoma with generalized metastases		INTERVAL BETWEEN ONSET AND DEATH 3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) 2001	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year	
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 **1956** to **1/31/60** and last saw him ^{her} alive on **1/31/60**
Death occurred at **4:45** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Max S. Franklin (Degree or title) M.D.	22b. ADDRESS 607 N. Grand Ave.	22c. DATE SIGNED 2/1/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/3/60	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol Cem.	23d. LOCATION (City, town, or county) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Herman Rindskopf, Inc. 5216 Delmar	25. DATE RECD. BY LOCAL REG. FEB 1 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>mjs</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Ketter
Licensed Embalmer No. 3880

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.