

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 22 1960

=60-017517

DEED

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 1138 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN University City		Length of stay in 1b 6 yrs.		c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 904 Purdue			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 904 Purdue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle Last FISHMAN			4. DATE OF DEATH Apr. 5, 1960 Month Day Year			
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 Apr. 21, 1902	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY H & M E	11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Samuel Kantor		13b. MOTHER'S MAIDEN NAME Frieda Meter		14. NAME OF HUSBAND OR WIFE Paul		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Florence Bleich 7330 Colgate			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compression of medulla due to increased intracranial pressure due to cerebral metastases.					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mo.	
DUE TO (b) Carcinoma of breast					7 mo.	
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) liver, lung, metastases to bone,					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)		
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 checked="" 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 Dec 27, 1956 to April 5, 1960 and last saw her ^{her} alive on April 4, 1960 . Death occurred at 3:10 am April 5, 1960 on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) Robert S. Wernhaus M.D.			22b. ADDRESS 7165 Delmar Sedona 30, Mo		22c. DATE SIGNED April 5, 1960	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur.	23b. DATE 4/6/1960	23c. NAME OF CEMETERY OR CREMATORY B'nai Amoona		23d. LOCATION (City, town, or county) University City, Mo.		
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson			25. DATE RECD. BY LOCAL REG. 4-6-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 3988

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.