

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 1960

032814

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 738 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived prior to institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS. MO</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>UNIVERSITY CITY. MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JEWISH HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8020 CORNELL</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (AKA) First <u>Israel M.</u> Middle <u>Schachter</u> Last <u>MORRIS ISRAEL SCHACHTER</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Whsle. Eggs</u>	11. BIRTHPLACE (City and state or country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>(unk) Schachter</u>		13b. MOTHER'S MAIDEN NAME <u>Charna Schwartz</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	17. INFORMANT <u>Mrs. Maurice Schetzler</u> Address <u>8020 Cornell</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GRANULOCYTIC LEUKEMIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 MO.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>204.1</u>					
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 checked="" type="checkbox"/> NO <input 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 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 <u>JULY 3. 1960</u> to <u>JULY 22 1960</u> and last saw him alive on <u>JULY 22/60</u> Death occurred at <u>6:30</u> P.m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Frank Cohen</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>10822 ST CHARLES ROAD, ST ANN MO</u>		22c. DATE SIGNED <u>7-23-60</u>	
23a. BURIAL, CREMATION, REAF (Specify) <u>Removal</u>	23b. DATE <u>7/24/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chevra Kadisha</u>	23d. LOCATION (City, town, or county) <u>University City, Mo.</u>		(State)
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JUL 24 1960</u>	26. REGISTRAR'S SIGNATURE <u>Roal Smith, M.D.</u> <u>M J. B.</u>		

(Licensed Embalmer's Statement on Reverse Side)

DED

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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Luigi J. Andberg*

Licensed Embalmer No. 4529

P. O. Address \_\_\_\_\_

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