

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Length of stay in 1b	c. CITY OR TOWN University City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 7329 Colgate Ave.

3. NAME OF DECEASED (Type or print) First Middle Last DAVID GLAZIER	4. DATE OF DEATH Month Day Year Sept. 23, 1960
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5. SEX Male	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 Unknown	9. AGE (last birthday) Abt. 58	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist	10b. KIND OF BUSINESS OR INDUSTRY Drug	11. BIRTHPLACE (City and state or country) Russia	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Louis Glazier	13b. MOTHER'S MAIDEN NAME Mollie Kaplan	14. NAME OF HUSBAND OR WIFE Etta Glazier
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown	17. INFORMANT Address Mrs. D. Glazier-7329 Colgate Ave.
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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) <u>Coronary thrombosis</u> DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>420-1</u>	INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>unknown</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>	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
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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
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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
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21. I attended the deceased from 9/21/60 to 9/23/60 and last saw him alive on 9/23/60
 Death occurred at 3 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Max A. Franklin M.D.</u>	22b. ADDRESS <u>607 N. Grand Ave.</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/25/60	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Herman Rindskopf, Inc. 5216 Delmar	25. DATE RECD. BY LOCAL REG. SEP 23 1960	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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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 *Peter Polachromille*

Licensed Embalmer No. *3691*
P. O. Address *St Louis*

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