

REGISTRATION DISTRICT NO. 318 PRIMARY REGISTRATION DISTRICT NO. 1003 REGISTRAR'S NO. 9662

-60-039536 STATE FILE NUMBER

FILED NOV 3 1960  
 ORDER OF CORONER'S OFFICE STATED ABOVE DEATH  
 BY AFFIDAVIT OF JAMES BLANK

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA City Hospital		d. STREET ADDRESS (If outside, give location) 530 Kingdell	

3. NAME OF DECEASED (Type or print) First MIDDLE Last BETTY BLANKE			4. DATE OF DEATH Month Day Year October 3, 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1920	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) East St. Louis, Ill.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Abe Moldovan		13b. MOTHER'S MAIDEN NAME Jennie Harris		14. NAME OF HUSBAND OR WIFE William	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT William Blanke 530 Kingdell		

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>Cerebral Anoxia</u> DUE TO (b) <u>History of Auto Accident</u> DUE TO (c) <u>934x</u>		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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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.)
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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
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ 4:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dabnis E. Taylor</u>	22b. ADDRESS 1300 Olive	22c. DATE SIGNED 10/11/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/5/1960	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	23d. LOCATION (City, town, or county) (State) University City Missouri
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24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson Avenue	25. DATE RECD. BY LOCAL REG. OCT 4 1960	26. REGISTRAR'S SIGNATURE <u>Wood Smith, M.D.</u>
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MEDICAL CERTIFICATION

**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 Walter J. Gindung

Licensed Embalmer No. 4229

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

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.