RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12432

-60-047397
STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
Length of stay in 1b: 70 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4911 Fountain
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 4911 Fountain
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First SARAH Middle CRYSTAL Last
4. DATE OF DEATH: Month Dec. Day 26 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: unk.
9. AGE (last birthday): ab. 75
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Russia
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Abr. Becker
13b. MOTHER'S MAIDEN NAME: Helen (unk)
14. NAME OF HUSBAND OR WIFE: Sam
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Amelia Becker
Address: 7920 Lafon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Many years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Heart Disease — " "
DUE TO (c) 443X
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Oct 1955 to Dec 26-60 and last saw her alive on Dec 21-60
Death occurred at 8 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. A. Brown (Degree or title) M.D.
22b. ADDRESS 3903 Olive St. St. Louis Mo.
22c. DATE SIGNED 12/27/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.
23b. DATE 12/27/60
23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagpdol
23d. LOCATION (City, town, or county) (State) Ladue, Mo.

24. FUNERAL DIRECTOR Berger Memorial
ADDRESS 4715 McPherson
25. DATE RECD. BY LOCAL REG. DEC 27 1960
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 8988

P. O. Address_____

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