

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED FILED JUN 29 1961 **318** Primary Registration District No. **1003** Registrar's No. **5906** STATE FILE NUMBER **-61-022415**

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 St. Louis		a. STATE Mo.	b. COUNTY St. Louis
Length of stay in lb 3 1/2 wks		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 St. Lukes Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8338 Archer Ave
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
CHARLES CHERVITZ			6-23-1961		

5. SEX male	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 6-19-1909	9. AGE (last birthday) 52	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) Tool & Die Maker	10b. KIND OF BUSINESS OR INDUSTRY McDonnell Aircraft	11. BIRTHPLACE (City and state or country) USSR	12. CITIZEN OF WHAT COUNTRY USA
--	--	---	---

13a. FATHER'S NAME Yehuda Leib Chervitz	13b. MOTHER'S MAIDEN NAME Faiga Spector	14. NAME OF HUSBAND OR WIFE Sylvia
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No	17. INFORMANT Address Mrs. Sylvia Chervitz 8338 Archer
--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 2 years
IMMEDIATE CAUSE (a) Asymptotic lebanica		
DUE TO (b)		
DUE TO (c) 204.0		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) pneumonia fungal, coronary arteriosclerosis		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 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 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 **1953** to **death** and last saw her/him alive on **6/23/61**
Death occurred at **7:25 pm 6/23/61** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert Paine M.D.	(Degree or title)	22b. ADDRESS 3720 Washington St Louis	22c. DATE SIGNED 6/24/61
--	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 6-25-61	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
---	-----------------------------	--	---

24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson	ADDRESS	25. DATE RECD. BY LOCAL REG. JUN 25 1961	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.
---	---------	--	---

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

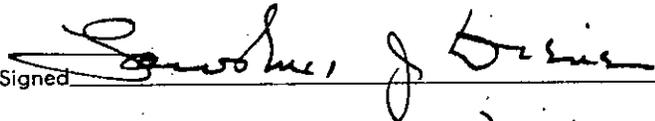
BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 8988

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.