

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027602

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2153

AMENDED

FILED AUG 11 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		c. CITY OR TOWN <u>Clayton</u>	
Length of stay in 1b <u>years</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>St. Louis County Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>7552 Oxford</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>STANLEY</u> First <u>CYTRON</u> Middle <u>CYTRON</u> Last			4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday) <u>Abt. 59</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leonson Box Co.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Gustave Cytron</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Tuvil</u>	
14. NAME OF HUSBAND OR WIFE <u>Shirley Cytron</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Mrs. Shirley Cytron</u>		Address <u>7552 Oxford Dr.</u>			

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 <u>just before year</u>
IMMEDIATE CAUSE (a)	<u>Myocardial Infarction</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (b) <u>Coronary insufficiency</u>		
	DUE TO (c) <u>Arteriosclerotic Heart Disease</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 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 <u> </u> a.m. <u> </u> p.m.	Month, Day, Year <u> </u>		
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 1950 to present and last saw her/him alive on July 12, 1961
Death occurred at about 4 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Samuel E. Schlichter M.D.</u>	(Degree or title)	22b. ADDRESS <u>8000 Boudoume</u>	22c. DATE SIGNED <u>8/1/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/2/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth Cem.</u>	23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>

24. FUNERAL DIRECTOR <u>Herman Rindskopf, Inc.</u>	ADDRESS <u>5216 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>8-1-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Peter D. Lukson

Licensed Embalmer No.

3691

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.