

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-034059

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9041 STATE FILE NUMBER

FILED OCT 13 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b <u>9 mths.</u> | c. CITY OR TOWN <u>University City</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>Jewish Hosp</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>809 Leland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>RAY</u> Middle <u>FISCH</u> Last <u>BOMZE</u> | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1961</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 16-1887</u> | 9. AGE (last birthday) <u>74</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Austria</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>Herschel Fisch</u> | 13b. MOTHER'S MAIDEN NAME <u>Unk.</u> | | 14. NAME OF HUSBAND OR WIFE <u>Hyman</u> |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>Unk.</u> | 17. INFORMANT <u>Rosalie Bomze</u> Address <u>809 Leland</u> |
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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>Cerebral Vascular Accident</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>331X</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1yr</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 checked="" 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 <u>6</u> a.m. / p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION <u>University City, Mo.</u> | COUNTY | STATE |
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| 21. I attended the deceased from <u>July 1, 1961</u> to <u>Sept 30, 1961</u> and last saw <u>him</u> live on <u>Sept 29, 1961</u> Death occurred at <u>6 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>Alvin S. Wenneker, M.D.</u> | 22b. ADDRESS <u>8112 Delmar</u> | 22c. DATE SIGNED <u>9/30/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u> | 23b. DATE <u>10/1/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>B'nai Amoona</u> | 23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Berger Memorial</u> ADDRESS <u>4715 McPherson</u> | 25. DATE RECD. BY LOCAL REG. <u>OCT 1 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Roal Smith, M.D.</u> |
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AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 Stephen J. Durie
Licensed Embalmer No. 3988

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.