

ISSUANCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035001

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8789

FILED SEP 27 1961

AMENDED
STATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF
ITEM NO.

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
a. COUNTY			a. STATE <u>MO.</u>		b. COUNTY
b. CITY (If outside corporate limits; give TOWNSHIP only)		Length of Stay in 1b	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JEWISH HOS'P</u>		Inside Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>5244 WATERMAN AVE</u>		Reside on Farm: Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GISELA</u> Middle <u>STRAUSS</u> Last <u>STRAUSS</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>20</u> Year <u>1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/8/86</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESS ALTERATION</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>LEOPOLD STRAUSS</u>		13b. MOTHER'S MAIDEN NAME <u>ERNESTEIN EHRMAN</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			17. INFORMANT Address <u>Mrs. Milton Landau #48 Kingsbury</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>3 years</u>
IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b)					
DUE TO (c) <u>420.0</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary emphysema - O'clock metastasis</u>				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	
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.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> 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 <u>1949</u> to <u>Sept 20 1961</u> and last saw her <u>live</u> on <u>Sept 20 1961</u> Death occurred at <u>8:20 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ray H. Freilag M.D.</u>			22b. ADDRESS <u>216 So. Kingsbury</u>		22c. DATE SIGNED <u>9-21-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>9/22/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai</u>		23d. LOCATION (City, town, or county) (State) <u>8400 Gravois Ave</u>
24. FUNERAL DIRECTOR <u>MAYER</u>		ADDRESS <u>4356 Lindell Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 22 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith M.D.</u>

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

Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo.

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.