

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-046429**  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11743**

AMENDED

**FILED DEC 21 1961**

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 <b>St. Louis</b>		a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		c. CITY OR TOWN <b>University City</b>	
Length of stay in lb		d. STREET ADDRESS <b>7329 Balson Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HONOR HONIGBERG</b>		4. DATE OF DEATH Month Day Year <b>December 17th, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		9. AGE (last birthday) <b>73</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Joseph Kranson</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Schwartzberg</b>	14. NAME OF HUSBAND OR WIFE <b>Morris Honigberg</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT Address <b>Morris Honigberg 7239 Balson Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Annular carcinoma of colon</b> DUE TO (b) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <b>153.8</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3-6 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic cerebral cordis pasc disease</b>			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 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 <b>June 1961</b> to <b>Dec 17, 1961</b> and last saw her <b>Dec 17, 1961</b> alive on <b>Dec 17, 1961</b> Death occurred at <b>2:20 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Wayne O. Gorka MD</b>		22b. ADDRESS <b>100 No Euclid</b>	22c. DATE SIGNED <b>12-17-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12/18/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Amoona Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b>
24. FUNERAL DIRECTOR <b>HERMAN RINDSKOPF INC. 5216 DELMAR</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 18 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>

**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 B. Dubucillet

Licensed Embalmer No. 3691

P. O. Address St. Mary's

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.