

MISSOURI DIVISION OF HEALTH AND WELFARE
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-004495

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5

STATE FILE NUMBER

FILED JAN 17 1962

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b	c. CITY OR TOWN <u>Clayton</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>BARNES HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7575 Parkdale</u>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>NMN</u> Last <u>SCHUCART</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>1</u> Year <u>1962</u>		
5. SEX <u>Female</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 <u>4-13-1892</u>	9. AGE (last birthday) <u>69</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At. Home</u>	11. BIRTHPLACE (City and state or country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Simon Tober</u>		13b. MOTHER'S MAIDEN NAME <u>Leah Greenberg</u>		14. NAME OF HUSBAND OR WIFE <u>Hymon Schucart</u>	
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 Address <u>Hymon Schucart, 7575 Parkdale, Clayton, Mo.</u>		
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>BILATERAL CARCINOMA OF THE OVARY WITH PERITONEAL AND PLEURAL METASTASES</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>175.0</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PULMONARY EMBOLUS</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 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 <u>NOV. 30, 1961</u> to <u>JAN. 1, 1962</u> and last saw her/him alive on <u>JAN. 1, 1962</u> Death occurred at <u>10:15 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Willard M. Allen</u>			22b. ADDRESS <u>M. D. BARNES HOSPITAL</u>		22c. DATE SIGNED <u>1/2/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-3-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>B'Nai Amonna Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>H. Rindskopf, Inc. 5216 Delmar</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JAN. 2 - 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u>

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 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 *R. E. B. Dickwell*

Licensed Embalmer No. 3691

P. O. Address *St Louis*

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.