

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044827

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10826 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

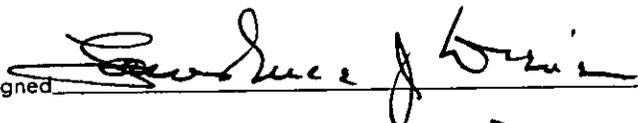
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>2 days</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		c. CITY OR TOWN <b>Olivette</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1219 Pioneer</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>SCHLANSKY</b> Last <b>SCHLANSKY</b>				4. DATE OF DEATH Month <b>11</b> Day <b>10</b> Year <b>1962</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>7/10/1902</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months <b>60</b> Days	IF UNDER 24 HR Hours <b>60</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Unk. Fishkin</b>			13b. MOTHER'S MAIDEN NAME <b>Unk.</b>			14. NAME OF HUSBAND OR WIFE <b>Sol</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Sol Schlansky 1219 Pioneer</b>			
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
IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) <b>4201</b>								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Scleroderma</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 <b>2</b> a.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>200 March 1957</b> to <b>present</b> and last saw her <b>alive</b> on <b>11-9-62</b> Death occurred at <b>2 a m</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Michael M. Bail, M.D.</b> (Degree or title)			22b. ADDRESS <b>4652 Maryland</b>			22c. DATE SIGNED <b>11/10/62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>	23b. DATE <b>11/11/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cheвра Kadisha</b>		23d. LOCATION (city, town, or county) <b>University City, Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Berger Memorial 4715 McPherson</b>				25. DATE RECD. BY LOCAL REG. REGISTRAR'S SIGNATURE <b>Nov. 10, 1962 Road 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  \_\_\_\_\_

Licensed Embalmer No. 3788

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.