

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048771

12648

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED JAN 10 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in lb	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		St. Louis		1 1/2 yrs.	Missouri		St. Louis		University City		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Jewish Center for Aged						825 Leland						
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
SARAH					STEPANSKY	December 31, 1962						
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR				
Female	White		Unknown	Ab. 83		Months Days		Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY					
At Home			Housewife		Russia		Russia					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE					
Unknown Yakofsky				Unknown			Dave					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No			None		Sidney Steppins		7468 Gannon					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a)												
cerebrovascular accident												
cerebral arteriosclerosis, severe												
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												
DUE TO (b)												
cerebral arteriosclerosis, severe												
DUE TO (c)												
3314												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)												
arteriosclerotic heart, dis. hiatus hernia												
Atherosclerotic Heart Disease; hiatal hernia with herniorrhaphy in past												
PART III. If deceased was female was pregnancy in last 90 days.												
No												
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					
	3-8-61		12-31-62		12-27-62							
21. I attended the deceased from <u>3-8-61</u> to <u>12-31-62</u> and last saw her alive on <u>12-27-62</u>												
Death occurred at <u>10:15 A.M. / 10:15 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <u>Robt. S. Mandelsohn</u> (title) <u>M.D.</u>						22b. ADDRESS <u>652 Maryland</u>			22c. DATE SIGNED <u>12-31-62</u>			
<u>Robert S. Mandelsohn, M.D.</u>						<u>4652 Maryland, St. Louis 8</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)		
Removal		1/2/1963		Chesed Shel Emeth			University City, Missouri					
24. FUNERAL DIRECTOR				ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE		
Berger Memorial				4715 McPherson Avenue				JAN 2 1963		<u>Loard Smith, M.D.</u>		

USE BLACK INK OR TYPEWRITER RIBBON

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. 4229

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.