

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FILED DEC 14 1948 318

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. 10535

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME BECKIE WALASH

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph Walash 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
 (Month) (Day) (Year)

8. AGE: Years About 63 Months - Days - If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Russia  
 (City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business Russ

12. Name Moses Korman

13. Birthplace Russia  
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Russia  
 (City, town, or county) (State or foreign country)

16. (a) Informant Miss Sadie Langah

(b) Address Kingsway Hotel

17. (a) Burial (b) Date thereof 12-5-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chevre Kadisha Cem.

18. (a) Signature of funeral director Herman Rindskopf, Inc.

(b) Address 5216 Delmar Blvd

19. (a) DEC 4 1948 J. B. Lacater  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 Address General 5843 Cote Brilliante  
 (If rural, give location)  
 (d) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 3rd  
 year 1948 hour 3 minute 45 A.M.

21. I hereby certify that I attended the deceased from 12/1/48  
 \_\_\_\_\_, 19\_\_\_\_, to Dec. 3rd, 1948  
 that I last saw her alive on Dec. 3rd, 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular Accident  
 Due to Hypertensive Cardiovascular Heart disease  
 Duration 2 yrs

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? U.R. Morrison Means of injury \_\_\_\_\_  
 23. Signature 1515 Lafayette DEC 5 1948  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John Ketter*

Licensed Embalmer No. *3880*

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 this body is not embalmed, fact should be so stated above.**