

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43104**
11151
Registrar's No.

FILED JAN 7 1950

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If rural, give location) 5801 Lotus	

3. NAME OF DECEASED (Type or Print) HARRY ZAVODNICK			4. DATE OF DEATH (Month) (Day) (Year) Dec. 26, 1949		
a. (First)	b. (Middle)		c. (Last)		

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH unk		9. AGE (In years) (last birthday) ab 58	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) construction		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY			

13a. FATHER'S NAME Meyer Zavodnisk		13b. MOTHER'S MAIDEN NAME Unk.		14. NAME OF HUSBAND OR WIFE Ethel	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Wm. Zavodnick 5801 Lotus			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Status Asthmaticus		Severe Herpes Zoster				3 days	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Bronchial Asthma				6 weeks	
		DUE TO (c) auricular fibrillation				15 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 112	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 241X	

22. I hereby certify that I attended the deceased from **Aug. 13, 1947**, to **12/26, 1949**, that I last saw the deceased alive on **12/26, 1949**, and that death occurred at **10:30A.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Alfred Feldman, M.D.		23b. ADDRESS 6341 Yorkwood		23c. DATE SIGNED 12/22/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/28/49	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel meth		24d. LOCATION (City, town, or county) (State) University City Mo.	
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DATE REC'D BY LOCAL REG. DEC 28 1949	REGISTRAR'S SIGNATURE J. B. Basater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 14715 McPherson		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed _____

James J. Anderson

Licensed Embalmer No. 4229

Signed _____
Student Embalmer

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.