

STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9841**

1. PLACE OF DEATH a. COUNTY 1		2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) a. STATE MISSOURI b. COUNTY 2	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		e. STREET ADDRESS (If rural, give location) 1804 ALLEN	
3. NAME OF DECEASED a. (First) GEORGE b. (Middle) PANSKY c. (Last) PANSKY		4. DATE OF DEATH (Month) (Day) (Year) NOV. 5 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH JUNE 26 1886
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAY LABORER	11. BIRTHPLACE (State or foreign country) ST. LOUIS MO
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME WILLIAM PANSKY	
13b. MOTHER'S MAIDEN NAME ANNA HRDLICKA		14. NAME OF HUSBAND OR WIFE	
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'S SIGNATURE OR NAME CHARLES PANSKY		ADDRESS 1804 ALLEN	

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) Cerebral vascular accident.		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Generalized arteriosclerosis.			
		DUE TO (c) Cerebral arteriosclerosis			
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"/>	

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) (STATE)	
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 334X	

22. I hereby certify that I attended the deceased from **10-22-51**, 19___, to **11-5-51**, 19___, that I last saw the deceased alive on **11-5-51**, 19___, and that death occurred at **4:50P** m., from the causes and on the date stated above.

23a. SIGNATURE H. L. Hays M.D.		23b. ADDRESS 1515 Lafayette		23c. DATE SIGNED 11-6-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Nov. 7 1951		24c. NAME OF CEMETERY OR CREMATORY NEW PICKER CEM.	
24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutie		ADDRESS 2906 Beavris	
DATE REC'D BY LOCAL REG. NOV 7 1951		REGISTRAR'S SIGNATURE Paul Smith			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....

Student Embalmer

Licensed Embalmer No.....

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.