

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39964

State File No.

No. 300
10.48

FILED DEC 1 1951

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1003 Registrar's No. 10078

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Texas b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Crockett 8:42	
c. LENGTH OF STAY (If this place) 6 days		d. STREET ADDRESS (If rural, give location) 107 N. 3rd. St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital			
3. NAME OF DECEASED a. (First) Mike		b. (Middle) —	
		c. (Last) Younas	
		4. DATE OF DEATH (Month) (Day) (Year) Nov. 12, 1951	
5. SEX M. O	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Dec. 11, 1879
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR II Months	IF UNDER 2 HRS. I Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Goods Store Owner		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Syria 8
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mrs. Hazel Younas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Hazel Younas, 107 N. 3rd. St. Crockett, Texas
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Polycythemia Vera INTERVAL BETWEEN ONSET AND DEATH 5 yrs. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 29th	
22. I hereby certify that I attended the deceased from Oct. 30, 1951, to Nov. 12, 1951, that I last saw the deceased alive on Nov. 12, 1951, and that death occurred at 4:20 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Lease Bromberg M.D. D		23b. ADDRESS Missouri Theatre Bldg 634 N. Grand	23c. DATE SIGNED 11/12/51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Nov. 13, 1951	24c. NAME OF CEMETERY OR CREMATORY Crockett City Cemetery	24d. LOCATION (City, town, or county) (State) Crockett, Texas
DATE REC'D BY LOCAL REG. NOV 13 1951	REGISTRAR'S SIGNATURE E. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING 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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4699

P. O. Address St. Charles, Mo.

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.