

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22846**
Registrar's No. **4466**

FILED JUN 21 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis | |
| 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 Clayton | |
| c. LENGTH OF STAY (in this place) 3 days | | 4. STREET ADDRESS (If rural, give location) 7515 Parkdale | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp. | | | |

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|--|--|-------------|--|-----------|--|
| 3. NAME OF DECEASED (Type or Print) MARY WYNER | | | 4. DATE OF DEATH (Month) (Day) (Year) May 12, 1952 | | |
| a. (First) | | b. (Middle) | | c. (Last) | |

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|-------------------------|----------------------------------|--|---------------------------------|--|---------------------------|-------------------------|---------------------------|--------------------------|
| 5. SEX Female | 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 86 | IF UNDER 1 YEAR Months | IF UNDER 6 WKS. Days | IF UNDER 24 HRS. Hours | IF UNDER 60 MIN. Min. |
|-------------------------|----------------------------------|--|---------------------------------|--|---------------------------|-------------------------|---------------------------|--------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) USSR | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Jacob Sacks | 13b. MOTHER'S MAIDEN NAME Ella Sandler | 14. NAME OF HUSBAND OR WIFE Isaac |
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| 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. None | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Fanny Sherman | ADDRESS 5741 McPherson |
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| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC DE COMPENSATION | | SEVERAL YRS. |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DIS. DUE TO (c) PULMONARY EMPHYSEMA | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | SEVERAL YRS. |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (STATE) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 4200 |
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22. I hereby certify that I attended the deceased from **MAY 10, 1950**, to **MAY 12, 1952**, that I last saw the deceased alive on **MAY 11, 1952**, and that death occurred at **745A m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Fanny Sherman | 23b. ADDRESS 634 N. Grand | 23c. DATE SIGNED 5/12/52 |
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|---|-----------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 5/14/52 | 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. MAY 13 1952 | REGISTRAR'S SIGNATURE Charles Smith MD | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Berger Memorial 4715 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed *Paul J. Audring*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4529*.....

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.