

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19900

State File No.

FILED JUN 1 - 1953

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

4804

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE			b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			c. LENGTH OF STAY (in this place) township) <u>2 1/2 months</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1438 E Grand</u>			20. <u>59</u>			d. STREET ADDRESS (If rural, give location) <u>6035 Kingsbury</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>SARAH</u>			b. (Middle)			c. (Last) <u>SHANKER</u>				
4. DATE OF DEATH (Month) (Day) (Year) <u>May 12 1953</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>unk</u>		
9. AGE (10 years last birthday) <u>46 65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>USSR</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Isidor Shanker</u>			13b. MOTHER'S MAIDEN NAME <u>unk</u>			14. NAME OF HUSBAND OR WIFE <u>Isidor</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dept. of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT'S SIGNATURE OR NAME <u>Sam Shanker</u>			ADDRESS <u>1700 Crystal Ter</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular accident (Thrombotic)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>	
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, generalized</u>						<u>years</u>	
			DUE TO (c)							
			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 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)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? <u>331X</u>				
22. I hereby certify that I attended the deceased from <u>Mar. 14</u> , 19 <u>53</u> , to <u>May 11</u> , 19 <u>53</u> that I last saw the deceased alive on <u>May 11</u> , 19 <u>53</u> , and that death occurred at <u>6 1/2</u> p. m., from the causes and on the date stated above.										
23a. SIGNATURE <u>Joe M. Orenstein, M.D.</u>						23b. ADDRESS <u>4500 Olive St</u>			23c. DATE SIGNED <u>5/12/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>5/13/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Graveside Park</u>			24d. LOCATION (City, town, or county) (State) <u>Union City Mo.</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>McBryen</u>			ADDRESS <u>4715 - Maple Ave</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

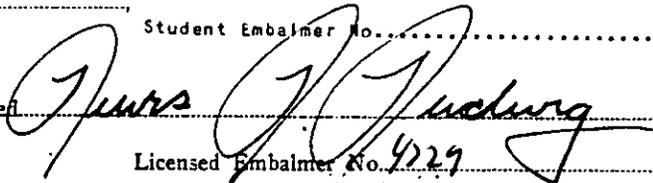
STATEMENT BY LICENSED EMBALMER

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.....



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.