THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3285

BIRTH NO. FILED FEB 10 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0906

1. PLACE OF DEATH
a. COUNTY: 0
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DEACONESS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): UNIVERSITY CITY 4376
d. STREET ADDRESS (If rural, give location): 7839 AHERN

3. NAME OF DECEASED (Type or Print)
a. (First): REVA
b. (Middle):
c. (Last): SMISSMAN

4. DATE OF DEATH (Month) (Day) (Year): Jan. 28, 1954

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: OCT. 25-1906
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months 3, Days 3 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (City and State or Foreign Country): ST. LOUIS MISSOURI
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: MORRIS H. LASKY
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: MORRIS SMISSMAN

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.: UNKNOWN
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: MORRIS SMISSMAN 7839 AHERN

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Mitral stenosis with Aricular fibralation — 20 years
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 ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 410X

22. *I hereby certify that I attended the deceased from* 1-11, 1950, *to* 1-28, 1954, *that I last saw the deceased alive on* 1-28, 1954, *and that death occurred at* 10 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Emueller, MD
23b. ADDRESS: 835 Mo. Theatre Bldg.
23c. DATE SIGNED: 1-29-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 12/29/54
24c. NAME OF CEMETERY OR CREMATORY: CHESED SHEL EMETH CEM
24d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

DATE REC'D BY LOCAL REG.: JAN 29 1954
REGISTRAR'S SIGNATURE: J. Earl Smith MD MDS
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Herman Rindskopf, Inc., 5216 Delmar

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed Peter B. Dubroullet

Licensed Embalmer No. 3691

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.