

FILED OCT 4 1954 THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **32227**
8484

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

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) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) University City #346	
c. LENGTH OF STAY (In this place) 1 day		d. STREET ADDRESS (If rural, give location) 7449 Gannon	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.			

3. NAME OF DECEASED a. (First) LILLIAN (Type or Print)			b. (Middle) SOKOLIK			c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1954		
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5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Marr.		8. DATE OF BIRTH AUG. 25, 1909		9. AGE (In years last birthday) 45		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 12 HRS. Hours _____ 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 (City and State or Foreign Country) <input type="radio"/> St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY USA		
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13a. FATHER'S NAME Meyer Stebelman			13b. MOTHER'S MAIDEN NAME Betsy Meyers			14. NAME OF HUSBAND OR WIFE Albert		
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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 Albert Sokolik		ADDRESS 7449 Gannon	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Breast ANTECEDENT CAUSES Cholesterol 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.						INTERVAL BETWEEN ONSET AND DEATH 2 1/2	
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19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? 170X		
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22. I hereby certify that I attended the deceased from **8/16**, 19**54**, to **9/15**, 19**54**, that I last saw the deceased alive on **9/11**, 19**54** and that death occurred at **7:00** p.m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]		(Degree or title) _____		23b. ADDRESS 4652 Maryland		23c. DATE SIGNED 9/15/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		24b. DATE 8/16/54		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.		24d. LOCATION (City, town, or county) (State) University City Mo.	
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DATE REC'D BY LOCAL REG. SEP 16 1954		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial		ADDRESS 4715 McPherson	
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(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Lawrence J. DeLuca
Licensed Embalmer No. 3988

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.