

FILED MAY 9 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13851

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3525

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. LENGTH OF STAY (in this place) 1 wk.		c. CITY OR TOWN University City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.		STREET ADDRESS (If rural, give location) 8020 Cornell			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)
SARAH SCHACHTER			April 20, 1955		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Marr.	8. DATE OF BIRTH October 14, 1887	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Austria	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME --- Teitelbaum	13b. MOTHER'S MAIDEN NAME ----	14. NAME OF HUSBAND OR WIFE Israel
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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 Israel Schachter	ADDRESS 8020 Cornell
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 hrs +
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Acute Stem Cell Leukemia		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
		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.		

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? 2044
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22. I hereby certify that I attended the deceased from Feb 1, 1945 to April 19, 1955, that I last saw the deceased alive on April 20, 1955, and that death occurred at 1:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE Frank Cohen	(Degree or title) MD	23b. ADDRESS 5899 Delmar, St Louis Mo	23c. DATE SIGNED 4/20/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	24b. DATE 4/22/55	24c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha	24d. LOCATION (City, town, or county) (State) University City Mo.
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DATE REC'D BY LOCAL REG. APR 21 1955	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial	ADDRESS 4715 McPherson
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B.P. (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 .....  
Signature of Student Embalmer

Signed *Lawrence J. Allen* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.