

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **16970**  
**4595**

FILED JUN 10 1955

|  |                                  |  |   |  |  |  |   |
|--|----------------------------------|--|---|--|--|--|---|
| BIRTH NO. _____  |                                  | REG. DIST. NO. <b>318</b>  |   | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. _____  |   |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b><br>b. COUNTY _____ |  |  |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b>   |                                  | c. LENGTH OF STAY (in this place)<br><b>2 1/2 hrs</b>  |   | c. CITY OR TOWN <b>St. Louis</b>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Jewish Hosp.</b>   |                                  |  |   | STREET ADDRESS (If rural, give location)<br><b>1456 Goodfellow</b>   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>BERNARD</b>  |                                  |  | b. (Middle) _____                       |  | c. (Last) <b>SCHACHMAN</b>                   |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>May 24, 1955</b> |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Wid.</b>  |   | 8. DATE OF BIRTH<br><b>Feb. 15, 1872</b>   | 9. AGE (In years last birthday)<br><b>83</b> |  | 10. UNDER 1 YEAR<br>Months _____ Days _____                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cabinet maker</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pullman car Co.</b>  |   | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Roumania</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13a. FATHER'S NAME<br><b>---Scachachman</b>  |                                  |  | 13b. MOTHER'S MAIDEN NAME<br><b>---</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>Rose</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk.</b>   |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Edna Scachachman 1456 Goodfellow</b>   |  |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebro Vasculai Accident</b><br>ANTECEDENT CAUSES<br>DUE TO (b) <b>Generalized Arteriosclerosis</b><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Arterio sclerotic gangrene foot.</b> |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b>  |   |
| 19a. DATE OF OPERATION _____   |                                  | 19b. MAJOR FINDINGS OF OPERATION _____   |   |  |  | 20. AUTOPSY?<br>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) (Minute) _____   |                                  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21f. HOW DID INJURY OCCUR?<br><b>331X</b>  |  |  |   |
| 22. I hereby certify that I attended the deceased from <b>May 10, 1955</b> , to <b>May 24, 1955</b> , that I last saw the deceased alive on <b>May 24, 1955</b> and that death occurred at <b>4:00</b> p.m., from the causes and on the date stated above. |                                  |  |   |  |  |  |   |
| 23a. SIGNATURE (Degree or title)<br><b>Caron Hendrie M.D.</b>  |                                  |  |   | 23b. ADDRESS<br><b>457 No. Kingshighway S/24/55</b>  |  | 23c. DATE SIGNED<br><b>5/24/55</b>   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Rem.</b>   |                                  | 24b. DATE<br><b>5/26/55</b>  |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>B' ai Amoona</b>  |  | 24d. LOCATION (City, town, or county) (State)<br><b>University City Mo.</b>  |   |
| DATE REC'D BY LOCAL REG.<br><b>MAY 25 1955</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith M.D.</b>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Berger Memorial 4715 McPherson</b>  |  |  |   |

C.P. (Licensed Embalmer's Statement on Reverse Side)

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

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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 *James A. Anderson*.....

Licensed Embalmer No.. *484*.....

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.