

FILED JAN 12 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 43016

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>2947</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u>				b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>Olivette</u>		c. LENGTH OF STAY (in this place) <u>5 wks.</u>		c. CITY OR TOWN <u>Olivette</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>8818 Cochise</u>				STREET ADDRESS (If rural, give location) <u>8818 Cochise</u>					
3. NAME OF DECEASED (Type or Print) <u>ESTELLE</u>			a. (First)		b. (Middle)		c. (Last) <u>Covitz</u>		
4. DATE OF DEATH <u>Dec. 17, 1955</u>		(Month) (Day) (Year)		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Marr.</u>		8. DATE OF BIRTH <u>Oct. 10, 1924</u>		9. AGE (In years last birthday) <u>31</u>		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Abe Schwartz</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Frank</u>		14. NAME OF HUSBAND OR WIFE <u>Harold</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Harold Covitz</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage.</u>				INTERVAL BETWEEN ONSET AND DEATH. <u>30 min</u>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Concitant Arteriosclerosis Right</u>		DUE TO (c) <u>Posterior Cerebral Artery</u>							
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 <u>331x</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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?					
22. I hereby certify that I attended the deceased from <u>11/23, 1954</u> , to <u>12/17, 1955</u> , that I last saw the deceased alive on <u>12/7, 1954</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Mona Allen M.D.</u> (Degree or title)				23b. ADDRESS <u>601 Humboldt Bldg</u>		23c. DATE SIGNED <u>12/18/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.</u>		24b. DATE <u>12/19/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel meth</u>		24d. LOCATION (City, town, or county) (State) <u>University City Mo.</u>			
DATE REC'D BY LOCAL REG. <u>12-17-55</u>		REGISTRAR'S SIGNATURE <u>Herbert P. De W...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Berger Memorial</u> ADDRESS <u>4715 McPherson</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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*W. D. Dindus*

Licensed Embalmer No. 488

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.