FILED SEP 7 1956

28987

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6839

ealth, Welfare ublic ervice

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis Mo. Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL Length of stay in 1b: 11 da

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: 4376 University/City, Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 7838 Cornell Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First: Herman Middle: Nathan Last: Polinsky
4. DATE OF DEATH Month 7 Day 21 Year 56
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan.11,1908
9. AGE (In years last birthday): 48
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator
10b. KIND OF BUSINESS OR INDUSTRY: Service Station
11. BIRTHPLACE (City and state or country): St.Louis,Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Philip Polinsky
14. MOTHER'S MAIDEN NAME: Lottie Polinsky
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 406-36-9900
17. INFORMANT: Mrs.Lillian Polinsky Address: 7838 Cornell

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lymphatic Leukemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 20410

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7-11-56 to 7-21-56 and last saw him alive on 7-21-56
Death occurred at 10:10 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: FR Bradley (Degree or title): M.D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 7/22/56

23a. BURIAL, CREMATION, REMOVAL (Specify): Rem.
23b. DATE: 7/23/56
23c. NAME OF CEMETERY OR CREMATORY: Beth Hamedrosh Hagodol
23d. LOCATION (City, town, or county) (State): Ladue,Mo.

24. FUNERAL DIRECTOR: Berger Memorial ADDRESS: 4715 McPherson
25. DATE RECD. BY LOCAL REG.: JUL 23 1956
26. REGISTRAR'S SIGNATURE: J Carl Smith MD MDB

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....39

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.