

Health, Welfare Public Service  
 300 1-56  
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

46216  
 STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's District No. **12330**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>8561 Oriole</b>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>8561 Oriole</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Elisabeth Pokorney</b>				4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-4-1909</b>		9. AGE (In years last birthday) <b>48</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Andrew Buxbaum</b>				14. MOTHER'S MAIDEN NAME <b>Elisabeth Unger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>499-12-3361</b>		17. INFORMANT Address <b>Frank Pokorney - 8561 Oriole</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach with general metastases</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Stomach with</b> DUE TO (c) <b>Generalized metastasis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>151X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 mon</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE				
21. I attended the deceased from <b>May 1957</b> to <b>Dec 1957</b> and last saw her <b>alive on Dec 16, 1957</b> Death occurred at <b>730</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>A. J. Sausville</b> (Degree or title) <b>M. D.</b>				22b. ADDRESS <b>8321 N. B. Dr.</b>		22c. DATE SIGNED <b>12-31-57</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE <b>12-26-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Edw Koch + Son - 3516 E. 14th</b>			25. DATE RECD. BY LOCAL REG. <b>DEC 23 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b> <b>m83</b>		

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.....  
*J. W. White*

Licensed Embalmer No. *42*

P. O. Address *St. Louis*

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.