

5997

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015720

FILED APR 21 1958

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4074

300  
-57 0

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in lb <u>53 years</u>	d. STREET ADDRESS (If outside, give location) <u>5797 Westminister</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>NMN</u> Last <u>DOBRANSKY</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1904</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.
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	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Moses Herman</u>		13b. MOTHER'S MAIDEN NAME <u>Ida (unk)</u>		14. NAME OF HUSBAND OR WIFE <u>Jacob</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>one</u>	17. INFORMANT Address <u>Jacob Dobransky 5797 Westminister</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS</u>					<u>3 YEARS</u>
DUE TO (c) <u>420.1</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES MELLITUS 25 YEARS</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>APRIL 8, 1958</u> to <u>APRIL 11, 1958</u> and last saw her alive on <u>APRIL 11, 1958</u> Death occurred at <u>11:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John D. Vavra</u> (Degree or title) <u>M. D.</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>4/12/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u>		23b. DATE <u>4/13/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>		23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>APR 15 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Smith MD</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

APRIL 11, 1950

DOBRAHNSKY

WMA

BERNIE

SS

1910

Miss

1000

Howland

1000

1000

1000

1000

1000

1000

1000

MISSISSIPPI DEPARTMENT OF HEALTH

1000

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 *Wm. A. Gudberg* \_\_\_\_\_

1000

1000

1000

Licensed Embalmer No. 4229

P. O. Address \_\_\_\_\_

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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.