

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023122  
STATE FILE NUMBER

5484  
REGISTRATION NO.

FILED JUN 16 1958

Registration District No. 318 Primary Registration District No. 1003

REGISTRAR'S NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 14 Jewish Hospital		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 27 900 Shandel Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SARAH BIALOCK			4. DATE OF DEATH Month Day Year May 25, 1958
5. SEX Female /	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unk. 9. AGE (In years last birthday) Abt. 79 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) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Russia 6 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Labe Gascowitz		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Morris Bialock-530 Donne Avenue Address 530 Donne Avenue 530 Shandel Drive
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary metastases Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of Colon DUE TO (c) Atherosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 153.8			INTERVAL BETWEEN ONSET AND DEATH 6 2/10 11 mo. Years
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. Month, Day, Year			
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 July 1945, to May 26, 1958 and last saw her alive on May 25, 1958 Death occurred at 8:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Llewellyn Sale Jr MD		22b. ADDRESS 100 N. Euclid 8	22c. DATE SIGNED 5/26/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/27/58	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol	23d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.
24. FUNERAL DIRECTOR Herman Rindskopf, Inc. 5216 Delmar		25. DATE RECD. BY LOCAL REG. MAY 26 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD

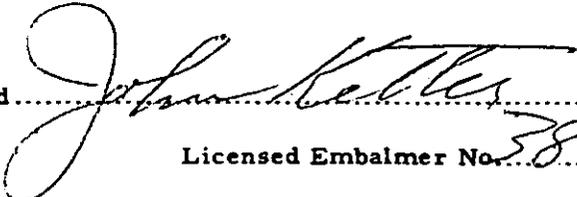
(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service  
300 1-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
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

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.....  
  
Licensed Embalmer No. 380

P. O. Address.....

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