

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023286

STATE FILE NUMBER

FILED JUN 16 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar No.

4907

5. 300

1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | |
| b. CITY OR TOWN St. Louis | | b. COUNTY Mo. St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 14 Jewish Hosp. | | d. STREET ADDRESS 9 wks. 27 th 8516 Old Bonhomme | |
| 3. NAME OF DECEASED (Type or print) First Middle Last SARAH FISHER | | 4. DATE OF DEATH Month Day Year May 7, 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"/> UNKNOWN | 8. DATE OF BIRTH Unknown |
| 9. AGE (In years last birthday) Ab. 93 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (City and state or country) Poland | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Unk. Melinek | | 14. NAME OF HUSBAND OR WIFE Samuel | |
| 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. None | |
| 17. INFORMANT Al Rosenblatt 7 Larksdale | | Address | |
| 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>Thrombosis iliac artery</u> DUE TO (b) <u>Art. Sclerosis, general</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hemiplegia, left C.V.A. 331X</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> |
| 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 <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>11/30/50</u> to <u>5/7/58</u> and last saw her alive on <u>5/7/58</u> Death occurred at <u>9th St.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Arthur E. Stravel, M.D.</u> | | 22b. ADDRESS <u>539 N. Grand</u> | |
| 22c. DATE SIGNED <u>5/7/58</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u> | | 23b. DATE <u>5/8/58</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</u> | | 25. DATE RECD. BY LOCAL REG. <u>MAY 8 '58</u> | |
| ADDRESS <u>CPerson</u> | | 26. REGISTRAR'S SIGNATURE <u>J. Paul Smith, M.D.</u> S.P. | |

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 *James G. Ludwig*
Licensed Embalmer No. *422 P*

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.