

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003678

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 231

FILED FEB 11 1959

| | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>University City</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>University City</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>6246 North Drive</u> | | Length of stay in lb <u>3 yrs.</u> | d. STREET ADDRESS (If outside, give location) <u>6246 North Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Ben</u> (aka <u>Benjamin</u>) Middle <u>Shanker</u> Last <u>Shanker</u> | | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</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>VIM</u> | 9. AGE (In years last birthday) <u>43</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail produce</u> | 11. BIRTHPLACE (City and state or country) <u>USSR</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13a. FATHER'S NAME <u>Gedaliah Shanker</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sarah (unk)</u> | | 14. NAME OF HUSBAND OR WIFE <u>Rose</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <u>no</u> unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Unk.</u> | 17. INFORMANT Address <u>Rose Shanker 6246 North Drive</u> | | |

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| 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>asymptomatic lateral sclerosis</u> <u>(Compulsive lateral sclerosis)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH. <u>15 months</u> <u>15 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Grandie ulcer</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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. _____ | | |

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| 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 <u>University City, Mo.</u> |
| 21. I attended the deceased from <u>Jan 1941</u> to <u>12/24/59</u> and last saw <u>her</u> alive on <u>12/20/59</u> Death occurred at <u>6:00 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE <u>John C. Murphy M.D.</u> (Degree or title) | 22b. ADDRESS | 22c. DATE SIGNED |

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.</u> | 23b. DATE <u>1/25/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u> | 23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u> | 25. DATE RECD. BY LOCAL REG. <u>1-24-59</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Arthur J. Delain*
Licensed Embalmer No. *8988*

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.