

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003755

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 366

300
-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u></u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bronx</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA County Hosp.</u>		Length of stay in lb <u>DOA.</u>	d. STREET ADDRESS (If outside, give location) <u>653 Briton St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SIDNEY</u> Middle <u></u> Last <u>SCHACTER</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</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>Aug. 2, 1930</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	9. AGE (In years last birthday) <u>28</u> IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11a. BIRTHPLACE (City and state or country) <u>Bronx, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Max Schacter</u>		13b. MOTHER'S MAIDEN NAME <u>Elsie (unk)</u>	14. NAME OF HUSBAND OR WIFE <u>Sandra</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if unknown) (If yes, give branch of service) <u>Yes Foreign</u>		16. SOCIAL SECURITY NO. <u>(unk)</u>	17. INFORMANT <u>Sandra Schacter</u> Address <u>653 Briton, Bronx, N.Y.</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>Multiple fractures of chest, shock and hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Operator of car involved in collision with another motor vehicle</u>	
20c. TIME OF INJURY <u>1:40 p.m.</u>		Hour <u>1:40</u> Month <u>2</u> Day <u>4</u> Year <u>59</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>highway</u>	20f. CITY, TOWN, OR LOCATION <u>Rural St. Louis</u> COUNTY <u>St. Louis</u> STATE <u>Missouri</u>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Raymond W. Lane</u> (Degree or title) <u>3</u>		22b. ADDRESS <u>Clayton, Mo.</u>	22c. DATE SIGNED <u>2/10/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Pine Lawn Long Island, N.Y.</u>
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-6-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

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 *Edward J. Burns*
Licensed Embalmer No. 3986
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.