Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011565
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 317 Primary Registration District No. 531 Registrar's No. 768

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY OR TOWN University City (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 738 Syracuse Length of stay in 1b 25 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ST LOUIS
c. CITY OR TOWN University City 4336 Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 738 Syracuse (If outside, give location) Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First IDA Middle Last GLADSTONE
4. DATE OF DEATH Month March Day 21 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH Unk.
9. AGE (In years last birthday) ab. 86 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (City and state or country) USSR 6
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Moishe Katz
13b. MOTHER'S MAIDEN NAME Doris (unk)
14. NAME OF HUSBAND OR WIFE Louis GLADSTONE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Sam Kolker Address 1100 W. Parkedge

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 Mar. 13, 53, to Mar 21, 59 and last saw her alive on Feb. 5, 59
Death occurred at 7:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Barrett L. Tarossy (Degree or title) M.D.
22b. ADDRESS 4500 Olive St
22c. DATE SIGNED Mar. 21 59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3/23/59
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth
23d. LOCATION (City, town, or county) (State) University City, Mo.
24. FUNERAL DIRECTOR Berger Memorial ADDRESS 4715 McPherson
25. DATE RECD. BY LOCAL REG. 3-23-59
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Part I. No symptoms will be listed. 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 .....

Licensed Embalmer No. 3988

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.