

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033580

FILED VS SEP 21 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **8 8134** STATE FILE NUMBER

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | Length of stay in 1b 5 1/2 yrs. | c. CITY OR TOWN St. Louis | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Hamilton Med. Center INSTITUTION | | d. STREET ADDRESS 5804a Lotus | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last LOTTIE Rosenblatt BIALOCK | | | 4. DATE OF DEATH Month Day Year Sept. 1, 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-20-1880 | 9. AGE (last birthday) 79 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Russia | 12. CITIZEN OF WHAT COUNTRY Russia | | |
| 13a. FATHER'S NAME Fallek Carlie | | 13b. MOTHER'S MAIDEN NAME Toba (unk) | | 14. NAME OF HUSBAND OR WIFE Wolf | | |
| 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 Address Albert Rosenblatt 8004 Canton | | | |

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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) Arteriosclerotic heart disease years | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Generalized Arteriosclerosis | |
| | DUE TO (c) 420.0 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Cerebral Arteriosclerosis | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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|---|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 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 10:30 a.m. 9/1/59 | | |

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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 University City, Mo. | COUNTY | STATE |
| 21. I attended the deceased from January 1919 to 9/1/59 and last saw her/him alive on 9/1/59 Death occurred at 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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|--|----------------------------|--|--|
| 22a. SIGNATURE Carson Skudini M.D. | (Degree or title) | 22b. ADDRESS 8230 Forsyth | 22c. DATE SIGNED 9/1/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. | 23b. DATE 9/3/59 | 23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth | 23d. LOCATION (City, town, or county) University City, Mo. |

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|--|---------|---|--|
| 24. FUNERAL DIRECTOR Berger Memorial 4715 14th Pherson | ADDRESS | 25. DATE RECD. BY LOCAL REG. SEP 2 1959 | 26. REGISTRAR'S SIGNATURE Keal Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Lawrence J. Dennis*

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.