

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020699

FILED VS JUN 8 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

Birth record - Jack Bolozky
 DOCUMENT St. Louis, Sept. 16, 1936
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF Informant

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7448 Gannon Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NANCY Middle BOLOZKY Last			4. DATE OF DEATH Month May Day 4 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widow <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/8/05	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice - President		10b. KIND OF BUSINESS OR INDUSTRY Ready to Wear	11. BIRTHPLACE (City and state or country) Venice, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Max Blumenfeld		13b. MOTHER'S MAIDEN NAME Rose Bleiweiss		14. NAME OF HUSBAND OR WIFE Ralph Bolozky	
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. Unk.		17. INFORMANT Address Ralph Bolozky-7448 Gannon Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of cerebral artery aneurysm					INTERVAL BETWEEN ONSET AND DEATH 19 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					330x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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	
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 _____ a.m. _____ p.m. Month, Day, Year _____					
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		COUNTY _____ STATE _____
21. I attended the deceased from 1954 to present and last saw her/him alive on 5/3/60 Death occurred at 7:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Herman M Rindkopf M.D.			22b. ADDRESS 457 N. Kings Highways		22c. DATE SIGNED 5/4/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/6/60	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem. St. Louis County, Mo.		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS Herman Rindkopf, Inc. 5216 Delmar		25. DATE RECD. BY LOCAL REG. MAY 5 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

Handwritten initials

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Peter P. Dukerovic

Licensed Embalmer No. 3691

P. O. Address J. Brown

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.