

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-048279

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Registration District No. 500 Primary Registration District No. 500 Registrar's No. 3743 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				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 Ladue			Length of stay in 1b		c. CITY OR TOWN Ladue		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION # 21 Clermont Lane			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) # 21 Clermont Lane		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HANNAH Middle POLLAK Last POLLAK				4. DATE OF DEATH Month DECEMBER Day 26th Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/6/89	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and state or country) Wisconsin		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME MAX FALKENSTEIN			13b. MOTHER'S MAIDEN NAME FRANCES FISHEL			14. NAME OF HUSBAND OR WIFE JACOB H. POLLAK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNK			16. SOCIAL SECURITY NO. UNK.		17. INFORMANT Mr. J.H. Pollak 21 Clermont Lane Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Cherry of abd. aorta Arteriosclerosis, general DUE TO (b) Cherry of abd. aorta DUE TO (c) Arteriosclerosis, general							INTERVAL BETWEEN ONSET AND DEATH a few minutes several years
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 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 1925 to Dec 26 '60 and last saw her him alive on Dec 7 1960 Death occurred at 1045 P on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Harriet B. Arnold M.D.				22b. ADDRESS 714 N. Taylor Ave		22c. DATE SIGNED 12-27-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/28/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Missouri		
24. FUNERAL DIRECTOR Herman Rindskopf Inc. 5216 Delmar ADDRESS				25. DATE RECD. BY LOCAL REG. 12-27-60		26. REGISTRAR'S SIGNATURE J. C. Murphy M.D.	

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Ketter

Licensed Embalmer No. 3880
P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.