

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8071 STATE FILE NUMBER -61-030660

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>				Length of stay in 1b		c. CITY OR TOWN <u>University City</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>7918 Cornell Avenue</u>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. AGE (last birthday)		
First Middle Last <u>LOUIS CYTRON</u>				Month Day Year <u>August 29, 1961</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
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>11/9/03</u>	9. AGE (last birthday) <u>57</u>		IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>		11. BIRTHPLACE (City and state or country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Meyer Cytron</u>			13b. MOTHER'S MAIDEN NAME <u>Bessie Landsman</u>			14. NAME OF HUSBAND OR WIFE <u>LaVerne Cytron</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>			16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT Address <u>Mrs. L. Cytron-7918 Cornell Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) _____								
DUE TO (c) <u>Cerebral arteriosclerosis</u>								
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. <u>331x</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <u>March 1955</u> to <u>present</u> and last saw her alive on <u>Aug 16 1961</u> Death occurred at <u>10 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Michael M. Carl M.D.</u>				22b. ADDRESS <u>4652 Maryland</u>			22c. DATE SIGNED <u>8-30-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8/31/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth Cem. St. Louis</u>			23d. LOCATION (City, town, or county) (State) <u>County, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Herman Rindskopf, Inc. 5216 Delmar</u>				25. DATE RECD. BY LOCAL REG. <u>AUG 30 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>		

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 *Peter Papowille*

Licensed Embalmer No. 3694

P. O. Address *Spokane*

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.