

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

8033 -61-030739  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. \_\_\_\_\_

FILED SEP 6 1961

DATE AMENDED

INSTEAD OF THIS RECORD-KEEP AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Clayton</b>	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>7537 Parkdale</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First **SARAH** Middle **FRENZEL** Last **FRENZEL**

4. DATE OF DEATH Month **Aug.** Day **28,** Year **1961**

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-80</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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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 **U. S. A.**

13a. FATHER'S NAME **Meyer Polishuk**

13b. MOTHER'S MAIDEN NAME **Ida Polishuk**

14. NAME OF HUSBAND OR WIFE **William Frenzel**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address **Gussie Frenzel 7537 Parkdale**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cerebral artery Thrombosis, Rt.**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) **Arteriosclerosis, Cerebral**

DUE TO (c) **332x**

INTERVAL BETWEEN ONSET AND DEATH  
**1 month**  
**1 year**

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.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO

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 **Feb 19 43** to **August 1961** and last saw her <sup>her</sup> <sub>been</sub> alive on **Aug 28/61**

Death occurred at **11:00 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Alfred Polakman M.D.**

22b. ADDRESS **634 N° Grand**

22c. DATE SIGNED **9/29/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal**

23b. DATE **8-30-61**

23c. NAME OF CEMETERY OR CREMATORY **Chesed Shel Emeth Cem.**

23d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Herman Rindskopf Inc 5216 Delmar**

25. DATE RECD. BY LOCAL REG. **AUG 29 1961**

26. REGISTRAR'S SIGNATURE **Boad Smith, M.D.**

**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 B. Dubois

Licensed Embalmer No. 3691

P. O. Address St. Louis, MO

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.