

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046088

FILED JAN 5 1962 318

Registration District No. Primary Registration District No. 1003

Registrar's No.

12046

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
AFFIDAVIT OF

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 St. Louis		c. CITY OR TOWN Richmond Heights	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Nursing Home		d. STREET ADDRESS 7745 Arthur	
3. NAME OF DECEASED (Type or print) First Middle Last Isaac A. Blotcky		4. DATE OF DEATH Month Day Year Dec, 23, 1961	
5. SEX Male	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 6-26-74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (City and state or country) Des Moines IOWA
13a. FATHER'S NAME Unk.		14. NAME OF HUSBAND OR WIFE Sarah Blotcky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address Myron Blotkey, 860 Alanson Dr	
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) cerebral vascular accident		1 day	
DUE TO (b) cerebral arteriosclerosis		4 1/2	
DUE TO (c) generalized arteriosclerosis		2 1/2	
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.	
331X		<input type="checkbox"/> Yes <input 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.	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 1960 to present and last saw her alive on Oct 10, 1961 Death occurred at about 3:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Samuel A. Schechter (Name and title) M.D. Samuel E. Schechter, M.D.		22b. ADDRESS 8000 Bonhomme 8000 Bonhomme	
22c. DATE SIGNED 12/24/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-26-61	23c. NAME OF CEMETERY OR CREMATORY Mt Sinai Cemetery	23d. LOCATION (City, town, or county) (State) / St. Louis County, Mo.
24. FUNERAL DIRECTOR Herman Rindskopf Inc 5212 Delmar		25. DATE RECD. BY LOCAL REG. DEC 28 1961	26. REGISTRAR'S SIGNATURE Road Smith, M.D.

O.H.
Helen L. Taylor
Coroner
12-27-61

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. DeBroail*

Licensed Embalmer No. 3691

P. O. Address *St. Louis*

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.