

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004546

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

268

STATE FILE NUMBER

AMENDED

FILED JAN 11 1962

Primary Registration District No.

Registrar's No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | 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 Hosp. | | d. STREET ADDRESS 1143 Mt. Olive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|-------------------------------|---|--|---|--------------------------------|---|
| 3. NAME OF DECEASED (Type or print) First ROSE Middle SMELANSKY Last | | | 4. DATE OF DEATH Jan. 8, 1962 Month Day Year | | | |
| 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 ab. 1895 | 9. AGE (last birthday) ab. 66 | 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) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) USSR | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME J. Julius Smelansky | | 13b. MOTHER'S MAIDEN NAME Naomi (unk) | | 14. NAME OF HUSBAND OR WIFE Sam | | |

| | | | |
|--|-------------------------|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT Sam Smelansky 1143 Mt. Olive | Address |
|--|-------------------------|--|---------|

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|---|--|---|----------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arteriosclerotic Heart Disease | | 2 weeks |
| | DUE TO (c) Myocardial Infarction? | | 2 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) +20.0H | | 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 | |

| | | |
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| 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.) |
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|---------------------------------------|------------------|
| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year |
|---------------------------------------|------------------|

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|--|--|---|--------|-------|
| 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 University City, Mo. | COUNTY | STATE |
|--|--|---|--------|-------|

21. I attended the deceased from **Apr. 1949** to **Jan 8 1962** and last saw her alive on **Jan 7, 1962**
Death occurred at **3 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|--------------------------------------|-----------------------------------|
| 22a. SIGNATURE Llewellyn Sale, Jr. M.D. (Deceased or title) | 22b. ADDRESS 100 N. Euclid | 22c. DATE SIGNED 1/8/62 |
|---|--------------------------------------|-----------------------------------|

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|--|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. | 23b. DATE 1/9/62 | 23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth | 23d. LOCATION (City, town, or county) University City, Mo. |
|--|----------------------------|--|--|

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| 24. FUNERAL DIRECTOR Berger Memorial 4715 Mc herson | 25. DATE RECD. BY LOCAL REG. JAN 8 1962 | 26. REGISTRAR'S SIGNATURE Loan Smith. M.D. |
|---|---|--|

DATE AMENDED

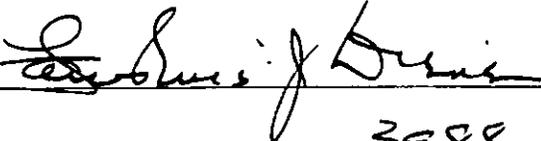
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 3988

P. O. Address _____

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.