

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048368

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12649**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		c. CITY OR TOWN <b>University City</b>		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>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>769 Syracuse Avenue</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>BIRDIE</b> Middle <b>SOLTZ</b> Last <b>GLICKSMAN</b>			4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1962</b>			5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12/25/94</b>		9. AGE (last birthday) <b>68</b>		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) <b>Saleslady</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Stix, Baer &amp; Fuller</b>				11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13a. FATHER'S NAME <b>Solomon Soltz</b>				13b. MOTHER'S MAIDEN NAME <b>Rachael Goodstein</b>				14. NAME OF HUSBAND OR WIFE <b>Robert Glicksman</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>				16. SOCIAL SECURITY NO. <b>Unk.</b>				17. INFORMANT <b>Mrs. Etta Handelman-<del>XX</del> 227 Lancaster</b>				Address							
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) <b>hemorrhage, massive</b>																			
DUE TO (b) <b>duodenal ulcer</b>																			
DUE TO (c) <b>541.0</b>												10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Collagen Disease</b>								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 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 Month, Day, Year 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 <b>6/22/1956</b> to <b>12/31/62</b> and last saw her alive on <b>12/31/62</b> Death occurred at <b>7:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <b>Wm. W. Drey MD</b>						22b. ADDRESS <b>634 N Grand</b>				22c. DATE SIGNED <b>1/2/63</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1/2/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Amoona Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>													
24. FUNERAL DIRECTOR <b>Herman Rindskopf, Inc. 5216 Delmar</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>JAN 2 1963</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>											

**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 P. Subramanian

Licensed Embalmer No. 3691  
P. O. Address Atlanta, 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.