

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

22832

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. Jewish Hospital)

File No.....  
Registered No. 6244  
St. .... Ward)

**2. FULL NAME**

Chieff Sopher  
(a) Residence. No. 1438 E. Grand Blvd. St. 9 Ward. (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose Sopher  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
about 69

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Russia

10. NAME OF FATHER David Sopher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Russia

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Russia

14. INFORMANT Morris Sopher  
(Address) 5427 Cabanne

15. FILED IN 10, 1929 REGISTRAR M. C. Starkey

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/9 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-11, 1929, at 6/9, 1929 that I last saw him alive on 6/9, 1929, and that death occurred, on the date stated above, at 10:40 A.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pericardial failure  
Chronic Myocarditis  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fracture of left femur falling to floor  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at Jewish Old Folks Home  
IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray  
(Signed) E. E. ... M. D.

19 (Address) French Hosp.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Chesed Shel Emeth DATE OF BURIAL June 10 1929

20. UNDERTAKER H. Rindskopf ADDRESS 5216 Delmar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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