

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

Do not use this space.

35983

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis*

(No. *1318*, *Sarsfield pl*)

File No.

Registered No. **9796**

St. Ward

2. FULL NAME

Unnamed Truskin

(a) Residence No. St. *21* Ward.

(Usual place of abode)

(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 <i>female</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Oct 1, 1929</i>		
7. AGE	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(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) <i>St. Louis</i>		
PARENTS	10. NAME OF FATHER <i>Samuel Truskin</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Quazia</i>	
	12. MAIDEN NAME OF MOTHER <i>Elizabeth Rein</i>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis</i>	
14. INFORMANT <i>S. Truskin</i> (Address) <i>1318 Sarsfield pl</i>		
15. <i>Oct - 1 1929</i> FILED <i>Max C. Stankloff</i> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

1. **16. DATE OF DEATH (MONTH, DAY AND YEAR)** *Oct 3 1929*

17. I HEREBY CERTIFY, That I attended deceased from *10/1/29* to *10/3/29* that I last saw him alive on *10/3/29* and that death occurred, on the date stated above, at *11 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute nephritis

130

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY) *128*

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *E. E. Cochran* M. D. *10/1, 1929* (Address) *1508 Franklin*

*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 <i>Beth Ham Hag</i>	DATE OF BURIAL <i>10/4 1929</i>
20. UNDERTAKER <i>H. W. Berger</i>	ADDRESS <i>4715 McCherem</i>

... should be carefully ... should state EXACTLY. PHYSICIAN'S should state ... Exact statement of OCCUPATION is very important. ... IS A PERMANENT ...

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No.....)

Registration District No. *991*
Primary Registration District No. *1003*

File No.....
Registered No. *9796*
St..... Ward.....

2. FULL NAME

Unnained Trushkin

(a) Residence. No..... St..... Ward.....
(Usual place of abode) (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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin. *2*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT..... (Address)

15.

FILED *DEC 21 1929* *Max C. Sturken* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

17. I HEREBY CERTIFY That I attended deceased from..... 19..... to..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Acute Nephritis
caused unknown information given
by Dr. B. C. Cochran
Days of U.S. 12-12-29*

CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

. 19 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

WRITE FULLY, WITH UNFADING INK--- THIS IS A PERMANENT RECORD

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1929
35083