

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

Do not use this space.

MAY 7 1937

1. PLACE OF DEATH

County.....
Township.....
City..... **St. Louis**

Registration District No.....
Primary Registration District No.....

**791
1003**

File No. **14332**
Registered No. **3828**
St. Ward)

2. FULL NAME **Peter Stein**

(a) Residence, No. **6424 Cates**
(Usual place of abode)

St. **NR** Ward.

U. City Mo.
(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) **Married**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Rose Stein**

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
ab 72

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Metals & Scrap Iron**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Poland**

13. NAME **Sam Stein**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Poland**

15. MAIDEN NAME **Selma (unk)**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Poland**

17. INFORMANT **Oscar Stein**
(ADDRESS) **704 Leiland, U. City, Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Chesed Shel Emet** DATE **4/11/37**

19. UNDERTAKER **H. B. Berg & Pherson**
(ADDRESS) **4715 W. 12th**

20. FILE **APR 10 1937** **J. T. Bredeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 9, 1937**

22. I HEREBY CERTIFY, That I attended deceased from **July**, 19**35** to **April 9**, 19**37**
I last saw **alive** on **April 8**, 19**37** Death is said to have occurred on the date stated above, at **9 A.M.**

The principal cause of death and related causes of importance were as follows:

Coronary occlusion

Date of onset **4/9/37**

Other contributory causes of importance **Arterio-sclerotic heart disease 7/35**
glomerulo-nephritis

Name of operation **Cerebral** Date of **7/35**
What test confirmed diagnosis? **Cerebral** Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **Yes, Tubercle**
(Signed) **Pete Tuholdt**, M. D.
(Address) **462 Taylor.**

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.

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