

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

13086  
 Do not use this space.

REC'D MAY 10 1939

1. PLACE OF DEATH

(a) County ..... 1 Registration District No. .... 791  
 (b) Township ..... Primary Registration District No. .... 1003  
 (c) City, St. Louis ..... (d) Street No. 6127 Columbia Ave., ..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 360 Marion Feder

(a) Residence, No. 510 Trinity, U-City, Mo. St. WR (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 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 George Feder

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 16, 1852

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
85	4	26	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

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

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

12. BIRTHPLACE (CITY OR TOWN) Brooklyn,  
 (STATE OR COUNTRY) New York

FATHER

13. NAME Jacob S Bascher

14. BIRTHPLACE (CITY OR TOWN) Germany  
 (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Anna Scherder

16. BIRTHPLACE (CITY OR TOWN) Germany  
 (STATE OR COUNTRY)

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from July, 1937, to April 12, 1939  
 I last saw her alive on April 12, 1939 Death is said to have occurred on the date stated above, at 4:30 p.m.  
 The principal cause of death and related causes of importance were as follows:

<u>Arteriosclerotic heart disease</u>	1938
<u>Senile dementia</u>	1935
<u>Chronic cholecystitis with stones</u>	? 1930

Other contributory causes of importance:

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... 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 ..... 19.....  
 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? No.  
 If so, specify Truman S. Drake M. D.  
 (Signed) J. B. Brudick  
 (Address) 114 N. Taylor

17. INFORMANT Leah Feder  
 (ADDRESS) 510 Trinity

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Brooklyn, M. Y. DATE Apr. 14, 1939

19. FUNERAL DIRECTOR (NAME) Alexander & Sons  
 (ADDRESS) 6175 Delmar, Blvd.

20. FILED APR 13 1939 J. B. Brudick  
 Local Registrar.

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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Dr. J. W. Binkley

7024 Division 7

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**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 .....

Registered Apprentice No. ...., working under my personal supervision.

Signed

*J. W. Binkley*

Licensed Embalmer No. *3653*

P. O. Address *6175 Delmar*

**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 this body is not embalmed, above space should be left blank.**