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.

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

13605
Do not use this space.

REC'D MAY 10 1939

791
1003
3947

1. PLACE OF DEATH

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. ..... 1003 Registered No. 3947

(c) or City St. Louis (d) Street No. Jewish Hosp. 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 51 Rebecca Cornfeld

(a) Residence, No. 4672 Page St. 12
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 6, 1892

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
46	9	21	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
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 .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Braila Roumania

FATHER
13. NAME Leib David
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Roumania

MOTHER
15. MAIDEN NAME Gittel Marcus
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Roumania

17. INFORMANT (ADDRESS) Mr. A. David 5918a Page

18. BURIAL, CREMATION, OR REMOVAL
PLACE Chesed Shel Emeth DATE 4/30, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H.B.Berger 4715 McPherson

20. FILED APR 28 1939 19 J.B. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 27, 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr. 24, 1939, to Apr. 27, 1939
I last saw her alive on Apr. 27, 1939. Death is said to have occurred on the date stated above, at 9:20 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Embolism sub clavian artery	4/24/39
Gangrene leftarm	4/24/39

Other contributory causes of importance:

Rheumatic heart dis.	years
mitral stenosis	years

Name of operation ..... Date of .....
What test confirmed diagnosis clinical Was there an autopsy? No

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? .....
If so, specify .....
(Signed) Llewellyn Sale, M. D.
(Address) 4500 Olive

(Licensed Embalmer's Statement on Reverse Side)

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 ME

HERBERT I. BERGER, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 1597

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

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