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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
STANDARD CERTIFICATE OF DEATH

Registration District No. 784

Primary Registration District No. 117

State File No. _____

Registrar's No. 1061

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Miriam Convalescent Home 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Ida Keller Arnstein
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Isaac Arnstein 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 20 1872
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Wilno, Poland
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER { 12. Name Eliezer Buyer

13. Birthplace Poland
(City, town, or county) (State or foreign country)

14. Maiden name Jeanette Kantrowitz

15. Birthplace Poland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bernard Keller

(b) Address 717 Syracuse

17. (a) Burial (b) Date thereof 6/15/1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bnai Amoona

18. (a) Signature of funeral director H. B. Berger

(b) Address 4715 McPherson

19. (a) JUN 14 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri 1 (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5244 Kensington
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 52 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13
year 1939 hour _____ minute 9 A. M.

21. I hereby certify that I attended the deceased from May 20, 1938, to June 13, 1939;
that I last saw her alive on June 7, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary infarction

Due to Arteriosclerotic heart disease

Due to _____

Other conditions 95%
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy no autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Albert E. Tausig (M. D. or other) M. D.

Address 4500 Olive St. Date signed 6/13/39

Duration 1 day
do not know

PHYSICIAN
Underline the cause to which death should be charged statistically

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..... 

Licensed Embalmer No..... *1597*

P. O. Address.....

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.