

27835

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **7335**

REC'D SEP 14 1939 **791**
Registration District No. **1003**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jewish Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 50yrs
years, months or days

3. (a) PRINT FULL NAME Shaindel Flieg 420

3. (b) If veteran, name war XX

3. (c) Social Security No. XX

4. Sex female **5. Color or race** white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Chaim Flieg

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. _____
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>ab. 73</u>			hr. _____ min.

9. Birthplace Radjwill U.S.S.R.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Joseph Wolf

13. Birthplace _____ U.S.S.R.
(City, town, or county) (State or foreign country)

14. Maiden name Esther Rachel Kremin

15. Birthplace _____ U.S.S.R.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J.W. Flieg

(b) Address 523 Westgate

17. (a) burial (Burial, cremation, or removal) **(b) Date thereof** 8/25/39
(Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

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

(b) Address 4715 McPherson

19. (a) AUG 25 1939 (Date of issue of this certificate) **(b) J. F. [Signature]**
(Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST LOUIS

(c) City or town University City
(If outside city or town limits, write "RURAL")

(d) Street No. 825 Midland
(If rural, give location)

(e) If foreign born, how long in U. S. A. 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25 year 1939 hour 1:20 minute _____ M.

21. I hereby/certify that I attended the deceased from September 1st, 1939, to Aug 25th, 1939
that I last saw her alive on Aug 25th, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death

Lymphatic Leukemia

Due to _____

Due to _____

Other conditions Artery sclerosis
Heart disease
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Olson P. [Signature] (M. D. or other)

Address 3617 N Grand Blvd Date signed 8/27/39

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.

STATEMENT BY LICENSED EMBALMER

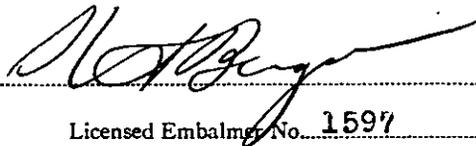
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

H. 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 comply with the above constitutes grounds for revocation of license.)

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