

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

SEP 14 1939

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

27944
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis
(b) Township St. Louis
(c) City St. Louis
(e) Length of residence in city or town where death occurred 3 1/2 yrs. mos. ds.

Registration District No. 791
Primary Registration District No. 1003
(d) Street No. Jennish

Registered No. 7444

2. PRINT FULL NAME

(a) Residence, No. 5090 1/2 Enright St. 12
(Usual place of abode, if no street address, write county or city)

(If death occurred in Hospital or Institution, write its name instead of street and number)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Rachel</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>unknown</u>		
7. AGE <u>abt. 63</u>	YEARS	MONTHS
	DAY	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Salesman</u>	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Grocery</u>	
	10. Date deceased last worked at this occupation (month and year)	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Russia</u>		
FATHER	13. NAME <u>Batgabael Steinberg</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Russia</u>	
MOTHER	15. MAIDEN NAME <u>Sarah Broman</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Russia</u>	
17. INFORMANT (ADDRESS) <u>Rachel Steinberg</u> <u>5090 1/2 Enright</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Chesed Shelometh</u> DATE <u>Aug. 30 1939</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>Funeral handler</u> <u>4469 Washington</u>		
20. FILED <u>AUG 30 1939</u> <u>J. P. Budek</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-29 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-29, 1939, to 8-29-39, 1939

I last saw him alive on 8-29, 1939. Death is said

to have occurred on the date stated above, at 2:10 p.m.

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

Cerebral Hemorrhage (Hemiplegia) etc.
Hypertensive Ht. Disease

Date of onset

Other contributory causes of importance:

Name of operation none Date of no

What test confirmed diagnosis? no Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury no, 19no

Where did injury occur? no
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no
Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify no

(Signed) Samr. Schneider, M. D.
(Address) 216 S. Kingshighway

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
_____ L. E. _____
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision. *Not Embalmed*
Signed _____
Licensed Embalmer No. _____

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.)