

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1939 OCT 14 1939
Registration District No. 791

791
1003

Primary Registration District No. _____

1. PLACE OF DEATH: 1

(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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County ST. LOUIS

(c) City or town St. Louis CLAYTON NR
(If outside city or town limits, write "RURAL")

(d) Street No. 6344 Southwood
(If rural, give location)

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

8. (a) PRINT FULL NAME Lillie Stern 365

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10
year 1939 hour 3 minute 25 A. M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Jake Stern

6. (c) Age of husband or wife if alive 55 years

21. I hereby certify that I attended the deceased from Sept 5, 1939, to Sept 10, 1939, that I last saw her alive on Sept 9, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

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

8. AGE: Years _____ Months _____ Days _____ If less than one day
About 50 hr. _____ min.

Due to Admission's Dream 470

Due to Non Tubercular

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation At Home A

11. Industry or business _____

12. Name Abe Wolff 7

13. Birthplace Austria 7
(City, town, or county) (State or foreign country)

14. Maiden name Addie Batavia

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

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature J. Jacobs

(b) Address 6342 Southwood

17. (a) Burial (b) Date thereof Sept 11
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

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? _____

18. (a) Signature of funeral director Herman Rudolph

(b) Address 5216 Delmar Blvd.

19. (a) SEP 11 1939 (b) J. F. Brudeck
(Date received local registration) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. R. Ferguson (M. D. or other)

Address Humeville Rd Date signed 9/11/39

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.....

Chas. Cooper

Licensed Embalmer No.....

3830

P. O. Address.....

5216 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.