

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42104

State File No.

JAN 12 1940

Registrar's No. 11227

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County 1
 (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 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 17 years
 (years, months or days)

3. (a) PRINT FULL NAME Sarah Yaffe 100

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Max Yaffe 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 12, 1879
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 4 18 hr. _____ min.

9. Birthplace Mohilev Russia
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business 7

12. Name Leib Gedaliah 7

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

14. Maiden name Charna Gitel

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

16. (a) Informant's own signature Jacob Rubin

(b) Address 951 Beach

17. (a) Burial (b) Date thereof 12/30/1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beth Ham Hag

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

(b) Address 4715 McPherson

19. (a) DEC 31 1939 (b) J. B. Budick
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town St. Louis 5
 (If outside city or town limits, write "RURAL")
 (d) Street No. 951 Beach
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 17 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 30
 year 39 hour 10⁰⁰ minute 5 A.M.

21. I hereby certify that I attended the deceased from 12-10, 1939, to 10-30, 1939;
 that I last saw h. e. r. alive on 10-30, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Sclerosis & Softening Duration _____

Due to Arteriosclerosis (genl) ✓

Due to Hypertensive Heart Disease ✓

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

Major findings: _____
 Of operations _____

Of autopsy _____

PHYSICIAN

 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Sam Schneider (M. D. or other) _____

Address 216 S. Kings Highway Date signed 12-26-39

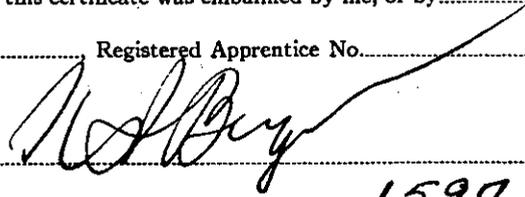
STATEMENT BY LICENSED EMBALMER

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.....



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.