

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limit, write "RURAL")
(d) Street No. 1319 Shawmut Pl.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Augusta Goldstein 432

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced WIDOW

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

7. Birth date of deceased Sept. 28, 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Solomon Stahl
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name (Heb) Pauline Stahl
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Steele
(b) Address 1319 Shawmut Pl.

17. (a) burial (b) Date thereof 8/7/40
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director [Signature]

(b) Address 4717 M^cPherson

19. (a) AUG 7 1940 (b) [Signature]
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6
year 1940 hour 3 minute _____ A.M.

21. I hereby certify that I attended the deceased from Aug 11
1940 to Aug 6 1940
that I last saw her alive on Aug 6 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral R^e Breach i
nitaxion to left lung & fluid
Due to also Terminal Bronchitis
pneumonia
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____
Of 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?

(Specify type of place)
(a) While at work (b) Means of injury _____

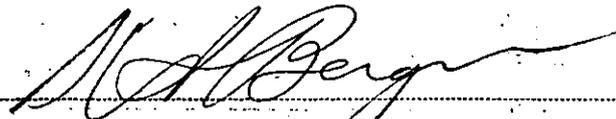
23. Signature [Signature] (M. D. or other) _____
Address 3903 Olive St. Date signed 8/6/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 1594

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.