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13-40
7-39
X23159

Registration District No.

791 ²⁵ 1940

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(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. 1
In this community 1 years, months or days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis CLAYTON NR
(d) Street No. 7449 Oxford
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Sophie Wittcoff

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Harry Wittcoff 6. (c) Age of husband or wife if live 1857 years
7. Birth date of deceased Feb. (Month) 1 (Day) 1857 (Year)

8. AGE: Years 83 Months 7 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Phillip Wittcoff

13. Birthplace Russia (State or foreign country)

14. Maiden name (unknown) (State or foreign country)

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

16. (a) Informant Mrs. Elias Freedman

(b) Address 7449 Oxford

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

17. (a) _____ (b) Date thereof 9-23-40 (Month) (Day) (Year)

(c) Signature of funeral director H. Ruds Kopp

(d) Address 5216 Delmar

19. (a) SEP 22 1940 (b) J. B. Paudel (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21 year 1940 hour 4 minute A.M.

21. I hereby certify that I attended the deceased from July 2, 1931, to Sept. 21, 1940; that I last saw her alive on Sept. 20, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Myelogenous leukemia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) Diabetes mellitus

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Alta E. Tansley (M. D. or other) MD

Address 4500 Olive St. Date signed 9/21/40

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

MOTHER FATHER

7
7
7

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 W Cooper

Licensed Embalmer No. 5830

P. O. Address 5216 Delmar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.