

STANDARD CERTIFICATE OF DEATH

Registration District No. **791** Primary Registration District No. **1003**

FILED OCT 26 1940

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

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 1
(Specify whether years, months or days) 45 years

3. (a) PRINT FULL NAME Rose Tenenbaum

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 Michael Tenenbaum 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased About 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Ab. 68 hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Unknown

18. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant M.B. Tenenbaum

(b) Address 1364 Clara

17. (a) Burial (b) Date thereof 9/30/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

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

(b) Address 4715 McPherson

19. (a) SEP 30 1940 (b) J.P. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 6
(If outside city or town limit, write "RURAL")
(d) Street No. 1364 Clara
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 45 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29
year 1940 hour 2:40 minute _____ M.

21. I hereby certify that I attended the deceased from 8/21/40
_____ 19____ to 9/29/40 19____

that I last saw him alive on 9/29/40 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Emema due to Cerebral thrombosis

Duration 3 wks.

Due to Arteriosclerosis, Cardio-vascular disease, Hypertension in

Due to _____

Other conditions (Include pregnancy within 3 months of death) 95

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 1

23. Signature J.M. Kotner (M. D. or other)

Address Jewish Hosp. Date signed 9/29/40

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 ME

....., Registered Apprentice No.
working under my personal supervision.

Signed *A. Berg*

Licensed Embalmer No. 1597

P. O. Address 4715 Mc Pherson

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.