

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2093

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Jewish Sanatorium of St. Louis
(d) Length of stay: In hospital or institution 2 months 28 days

In this community
years, months or days

8. (a) PRINT FULL NAME Barnholtz Mollie

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 MORRIS BARNHOLTZ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUG 15 1890

8. AGE: Years 50 Months 2 Days 21 If less than one day hr. _____ min. _____

9. Birthplace RUSSIA

10. Usual occupation AT HOME

11. Industry or business _____

12. Name Wolf FRACHTMAN

13. Birthplace RUSSIA

14. Maiden name SPRINTZA (UNK)

15. Birthplace RUSSIA

16. (a) Informant HYMAN BARNHOLTZ

(b) Address 740 HEMAN

17. (a) BURIAL (b) Date thereof 11/7/40

(c) Place: burial or cremation CHESED SHEL EMEH

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

(b) Address 4715 McRAESON

19. (a) NOV 7 1940 (b) [Signature]

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis
(d) Street No. 1820 S. Broadway
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 6
year 1940 hour 6 minute 45 M.

21. I hereby certify that I attended the deceased from August 8, 1940, to November 6, 1940;
that I last saw her alive on November 6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary occlusion

Due to Arteriosclerotic heart disease

Due to _____

Other conditions Bronchial asthma, Diabetes mellitus

Major findings: Of operations 59

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? _____
(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 [Signature] (M. D. or other) _____
Address [Signature] Date signed _____

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

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

MOTHER FATHER

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 *H. Berger*

Licensed Embalmer No. 1597

P. O. Address 1.

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.