No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 24 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39972

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 9680

000 17 9

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 1 mo.

2. USUAL RESIDENCE OF DECEASED: 000 17 9

(a) State Missouri (b) County —

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5370 Pershing Ave
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME FRANCES ROTHFIELD

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 married

6. (b) Name of husband or wife Joseph Rothfield

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

7. Birth date of deceased Oct. 31 (Month) 1896 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
45	1	6	hr. min.

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

10. Usual occupation at home

11. Industry or business

FATHER 12. Name Morris R. Broida

FATHER 13. Birthplace Kaunas Lithuania Russia (City, town, or county) (State or foreign country) 6

MOTHER 14. Maiden name Sarah Simon

MOTHER 15. Birthplace Kaunas Lithuania Russia (City, town, or county) (State or foreign country) 6

16. (a) Informant Joseph Rothfield

(b) Address 5370 Pershing

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Dec. 7, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Pittsburgh Penn

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson

19. (a) DEC 7 1941 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6 year 1941 hour 4 minute 55 P.M.

21. I hereby certify that I attended the deceased from Dec. 5, 1941, 19..., to Dec. 6, 1941; that I last saw her alive on Dec. 6, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac Failure	
Respiratory Failure	
Due to 1. Intrinsic Asthma	5 yrs.
2. Status Asthmaticus	48 hrs.
Due to 3. Myocardial damage	6 mo.
4. Cardiac decompensation & Terminal shock	24 hrs.

Other conditions none
(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Russell J. Cider (M. D. or other)

Address BARNES HOSPITAL Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 4715 McPherson

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, fact should be so stated above.