

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 25 1948

1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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: Jewish Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 50 yrs
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 limits, write "RURAL")
(d) Street No. 5917 DeGiverville
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Mary Steinberg

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, widowed

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

7. Birth date of deceased (unknown)
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
ab. 78 hr. min.

9. Birthplace Volhynia Poland Russia 6
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Jacob Kravitz

13. Birthplace Poland 4
(City, town, or county) (State or foreign country)

14. Maiden name (unk)

15. Birthplace Poland 4
(City, town, or county) (State or foreign country)

16. (a) Informant A. E. Frankel

(b) Address 5917 DeGiverville

17. (a) burial (b) Date thereof 3/17/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emet

18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 McPherson

19. (a) MAR 17 1948 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16th
year 1943 hour 6 minute 30 P. A. M.

21. I hereby certify that I attended the deceased from March 13 1943 to March 16 1943
that I last saw h. er alive on March 16 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration 4 days
Due to Arteriosclerotic Heart Disease

Due to _____
Other conditions 93
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) _____
(e) Means of injury _____
23. Signature Joe M. Craven (M. D. or other) 3/17/43
Address 64500 Olive St Date signed

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.....

Licensed Embalmer No.....

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, fact should be so stated above.