

Registration District No. 217

Primary Registration District No. 200

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

5106

1. PLACE OF DEATH:

(a) County Missouri

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

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

(d) Length of stay: In hospital or institution 32 yrs
(Specify whether years, months or days)

In this community 32 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 3

(c) City or town University City
(If outside city or town limits, write "RURAL")

(d) Street No. 765 Syracuse
(If rural, give location)

(e) Registered Alien
Citizen of foreign country? 1 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME FANNIE SCHOLNICK NIK

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 Sam Schkolnick

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

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

8. AGE: Years Months Days If less than one day

ab. 68 hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Baruch Moses Zaichik

{ 13. Birthplace Russia 6
(City, town, or county) (State or foreign country)

{ 14. Maiden name Rachel (unk)

{ 15. Birthplace Russia 6
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Gimpelson

(b) Address 765 Syracuse

17. (a) burial (b) Date thereof 4/22/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chapel Shalom Emeth

18. (a) Signature of funeral director Shalom Memorial

(b) Address 4715 McPherson

19. (a) APR 22 1943 (b) C. J. McQuinn MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1943 hour 3 minute 30 p. M.

21. I hereby certify that I attended the deceased from January
1943 to April 20, 1943
that I last saw her alive on April 18, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Esophagus Duration 2 yrs

Due to _____

Due to _____

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

Major findings: Of operations 460

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)

() Means of injury? _____

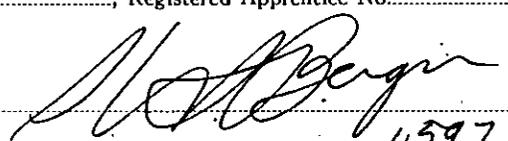
23. Signature Stotes, Inokobe (M. D. or other) _____

Address 462 N. Taylor Date signed 4/24/43

STATEMENT BY LICENSED EMBALMER

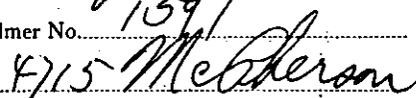
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....



Licensed Embalmer No. ¹⁵⁹⁷.....

P. O. Address.....



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.