

1941 JAN 12 10 18

State File No. _____

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **11936**

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 HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 DAYS**
In this community **16 YEARS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **000**
(c) City or town **ST. LOUIS** (If outside city or town limits, write "RURAL")
(d) Street No. **1388 Blackstone** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Chia SURAH TEZENHAUS**
3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NO**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **31**
year **1943** hour **5** minute **45 A.M.**

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife _____ 6. (c) Age of ~~husband~~ **73** years
7. Birth date of deceased **UNKNOWN**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec. 29**, 1943, to **Dec. 31**, 1943;
that I last saw h. **ET** alive on **Dec. 30**, 1943;
and that death occurred on the date and hour stated above.

8. AGE: Years **Abt 72** Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death **Cerebrovasc. accident - (hemorrhage?)** Duration **5 hrs**
Due to **arteriosclerosis, cerebral** **10 yrs**

9. Birthplace **RUSSIA**
(City, town, or county) (State or foreign country)

Due to **1003**
Other conditions **bronchial asthma** **10 yrs**
(include pregnancy within 3 months of death)

10. Usual occupation **HOUSEWIFE**

arteriosclerotic heart disease **PHYSICIAN**

11. Industry or business of **HOUSEWORK**

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

12. Name of FATHER **ABRAHAM Jacob BERMAN**

13. Birthplace **RUSSIA**
(City, town, or county) (State or foreign country)

14. Maiden name **BASA BALA ZERSHIN**

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

16. (a) Informant **Anna Wald**

(b) Address **1388 Blackstone**

17. (a) **BURIAL** (b) Date thereof **12 31 43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cherokh Kodisha**

18. (a) Signature of funeral director **W. J. Wald**

(b) Address **1169 W. 4th Street**

19. (a) **DEC 31 1943** (b) **J. J. Blodick**
(Date received local registrar) (Registrar's signature)

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 _____
23. Signature **Joseph F. ...** (M. D. or other)
Address **Jewish Hospital, St. Louis** Date signed **Dec 31/43**

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

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.

Not Embalmed

Signed *W. J. Penhender*
Licensed Embalmer No. *3869*

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.