

Form No. 2  
DOM-5-43  
Rev. 5-17-39  
I X3687

26573

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 21 1944

318

Primary Registration District No. \_\_\_\_\_

Registrar's No. 6984

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 \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community 39 years  
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. 5939 Washington  
(If rural, give location)

(e) Citizen of foreign country? Alien #4,452,179 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Goldie Schwartz

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 Carl Schwartz

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

7. Birth date of deceased Mar. 28, 1861  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
83	4	10	_____ hr. _____ min.

9. Birthplace Focsani Roumania  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Simcha Pezin

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

14. Maiden name Hai Hinda

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

16. (a) Informant Louis Schwartz

(b) Address 6219 Alamo

17. (a) Burial (b) Date thereof 8/10/1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bnai Amoona

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson

19. (a) AUG 10 1944 (Date of registration)  
J. F. Brebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8  
year 1944 hour 11 minute \_\_\_\_\_ a.m.

21. I hereby certify that I attended the deceased from Feb 12  
1944 to Aug 8 1944  
that I last saw him alive on Aug 8, 1944 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death  
broncho pneumonia Duration 36 hrs

Due to arterio-sclerotic heart disease many years

Due to generalized arterio-sclerosis many years

Other conditions: \_\_\_\_\_  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

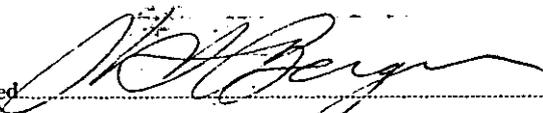
23. Signature Joseph Magidon (M. D. or other) MD.  
Address 520 W. 1st St. Date signed 8-8-44

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.

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.**