

S. No. 2
DM-5-43
v. 5-17-39
P. I X36571

FILED JAN 31 1945 **318**

1003

Registration District No. _____ Primary Registration District 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:
St. Lukes 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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____

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

(d) Street No. 4943 Winona
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BECKIE FORMAN

3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex Female **5. Color or race** White **6. (a) Single, widowed, married, divorced** Married

6. (b) Name of husband or wife Walter Forman **6. (c) Age of husband or wife if alive** 58 years

7. Birth date of deceased Sept. 2 1886
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>4</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Housework

12. Name Joseph Scallet **13. Birthplace** Russia
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Orenstein **15. Birthplace** Russia
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Forman

(b) Address 4943 Winona

17. (a) Burial Chesed Shel Emeth **(b) Date thereof** 1-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Openhandler
(b) Address 4469 Washington Blvd

19. (a) Date JAN 23 1945 **(b) Signature** J. J. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23
year 1945 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec 13 1944 to Jan 23 1945
that I last saw her alive on Jan 22 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure **Duration** 3 mos

Due to chronic endocarditis and chronic myocarditis **36 years**
 rheumatic fever in youth **20 years**

Other conditions Pneumonia pleural effusion **1 month**
(Include pregnancy within 3 months of death)

Major findings: 92C

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) **(c) Means of injury** _____

23. Signature Walter Forman **(M. D. or other)** _____

Address 3720 Washington Blvd **Date signed** 1-23-45

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.....

W. Z. Penhault
.....
Licensed Embalmer No. *3669*
.....

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.