

FILED APR 23 1945

Registration District No. 317A

Primary Registration District No. 1002

Registrar's No. 768

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
749 WESTGATE - HOME  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 years  
(Specify whether years, months or days)

In this community 28 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 749 Westgate  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SADIE FISHMAN

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24  
year 1945 hour 9:30 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1, 1945, to 3-24, 1945; that I last saw her alive on 3-24, 1945; and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife SAM FISHMAN 6. (c) Age of husband or wife if alive 65 years

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

Immediate cause of death: Cowary, Disease Duration 3 Mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

8. AGE: Years 61 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 9/6

Of autopsy \_\_\_\_\_

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

10. Usual occupation HOUSEWIFE

11. Industry or business HOUSE WORK

12. Name MOTEL BELES+EFISKY

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

14. Maiden name RIVRA

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

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? \_\_\_\_\_

16. (a) Informant Sam Fishman

(b) Address 749 Westgate

17. (a) BURIAL (b) Date thereof 3-27-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chest St. L. METH

18. (a) Signature of funeral director Odehlander

(b) Address 4469 Washington

19. (a) MAR 27 1945 (b) E. E. McCowan  
(Date received from registrar) (Registrar's signature)

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

23. Signature Dr. P. A. Stahl (M. D. or other) \_\_\_\_\_  
Address 462 N. Taylor Date signed 3/25/45

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

106  
3  
5

MOTHER FATHER

JAN 7 1949

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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. B. Chandler*

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.