

FILED APR 1 1948

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **731**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**
(b) City or town **Pine Lawn**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Shamrock Rest Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 weeks**
(Specify whether
In this community **25 years**
years, months or days)

3. (a) PRINT FULL NAME **IDA SARA ROSENBAUM**

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

7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt. 75 hr. _____ min.

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

10. Usual occupation **Housework**

11. Industry or business **Housewife**

12. Name **Nusen Staler**

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

14. Maiden name **Suma Rachel Forman**

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

16. (a) Informant **Moses Rosenbaum**

(b) Address **1442a Clara**

17. (a) **Burial** (b) Date thereof **3-26-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chevrah Kadisha**

18. (a) Signature of funeral director **Openshider**

(b) Address **4469 Washington Blvd.**

19. (a) **3-28-46** (b) **Joseph Macidon**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **6000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **1442a Clara** **9**
(If rural, give location) **1**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **25**
year **1946** hour **8** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **April 10**, 19**36** to **Mar 25**, 19**46**
and that death occurred on the date and hour stated above.
that I last saw h.w. alive on **Mar 25**, 19**46**

Immediate cause of death **Cerebral hemorrhage** Duration **3 days**

Due to **arterio-sclerosis** many years
generalized **836**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none** PHYSICIAN _____

Of autopsy **none** 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 Macidon** (M, D, or other) **MD**
Address **520 W. 1st St.** Date signed **3/25/46**

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.....
J. B. Benharder

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.