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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10834

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

FILED APR 1 1946

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 701

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

1. PLACE OF DEATH:

(a) County JENNINGS St Louis

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

(c) Name of hospital or institution:  
ELMS NURSING HOME  
(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 St Louis 96

(c) City or town JENNINGS  
(If outside city or town limits, write "RURAL")

(d) Street No. 2520 Mc Luan  
(If rural, give location)

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

3. (a) PRINT FULL NAME RACHEL ZUCKER

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 23  
year 1946 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan. 20  
1946 to Mar 23 1946  
that I last saw her alive on Mar. 23 1946  
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 WIDOWED

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

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

Immediate cause of death chronic myocarditis Duration 1 yr?

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

Due to 93d

8. AGE:	Years	Months	Days	If less than one day
<u>Abt</u>	<u>73</u>			hr. _____ min.

Other conditions Arteriosclerosis 10 yrs?  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

10. Usual occupation HOUSEWIFE

11. Industry or business HOUSEWORK

12. Name DAVID KAHN

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

14. Maiden name SOPHIE

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

16. (a) Informant Harry Zucker

(b) Address 5820 Kennedy

17. (c) BURIAL (b) Date thereof 3-24-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BINA AMOON

18. (a) Signature of funeral director Odenhandler

(b) Address 1469 Washington

19. (a) 3/25/46 (b) E. W. Tarrance, D.  
(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)  
Means of injury \_\_\_\_\_

23. Signature Lucretia L Arnold (M. D. or other) MD.  
Address 1449 Mc Luan Date signed 3/24/46

APR 5 1946

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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.....

*J. J. Penhander*  
.....  
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.