

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11679

State File No. _____

FILED MAR 30 1946
Registration District No. _____

Primary Registration District No. _____

Registrar's No. 2732

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: Barnes Hospital, 0
(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

3. (a) PRINT FULL NAME Clara B. Snitzer

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 Fred Snitzer 6. (c) Age of husband or wife if alive 44 years

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

8. AGE: Years Months Days If less than one day

About 40 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER, FATHER { 12. Name Wolf Meisenberg

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

14. Maiden name Anna Lang

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

16. (a) Informant Mr. Fred Snitzer

(b) Address 5369 Cabanne Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-46
(Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth Cen.

18. (a) Signature of funeral director H. Rindskopf

(b) Address 5216 Delmar Blvd.

19. (a) MAR 22 1946 (Date received by registrar) (b) J. F. Braduk (Registrar's signature)

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. 5369 Cabanne Avenue
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21
year 1946 hour 8 minute 41 a.m.

21. I hereby certify that I attended the deceased from January 31, 1946 to March 21, 1946
that I last saw her alive on March 21, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of ovary with metastasis

Due to _____

Due to _____

Other conditions HA
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 J. F. Braduk (M. D. ~~XXXX~~)
Address Barnes Hospital Date signed 3/21/46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

(Licensed Embalmer's Statement on Reverse Side)

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.....

A. R. Burgess

Licensed Embalmer No.....

4029

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.