

FILED MAR 3 1947  
318

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: Missouri Baptist Hospital  
(d) Length of stay: In hospital or institution 8 wks.  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County  
(c) City or town UNIVERSITY CITY  
(d) Street No. 718 Leland Ave.  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Lillian Goffstein

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 Meyer Goffstein 6. (c) Age of husband or wife if alive 80 years

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

8. AGE: Years Months Days If less than one day  
About 74 -- -- hr. min.

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

10. Usual occupation

11. Industry or business

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Mollie Razeper

(b) Address 5223 Enright Ave.

17. (a) Burial (b) Date thereof 2-18-1947 (Month) (Day) (Year)

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

18. (a) Signature of funeral director Herman Rindberg

(b) Address 5216 Delmar Blvd.

19. (a) Date received local registrar J. F. Bredecek (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17 year 1947 hour minute 05 P.M.

21. I hereby certify that I attended the deceased from 12/24/1946 to 2/17/1947 that I last saw him alive on 2/17/47 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral sclerosis, Chronic Nephritis

Due to: Fracture of hip

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

Major findings: 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) ood

(b) Date of occurrence 12-23-47

(c) Where did injury occur? fall at home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(e) Means of injury

23. Signature W. R. White (M. D. or other)

Address 4500 Olive Date signed 2/18/47

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

20  
17  
9

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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.....  
.....  
Licensed Embalmer No.....  
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.**