

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36871

11836

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 625-

Registration District No. 317 Primary Registration District No. 306F

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Marys Hospital ( )  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town University City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 709 Limit Ave.,  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SARAH SHECHTMAN  
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 Michael Shechtman 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March 16  
year 1947 hour 5 minute 45 P.M.  
21. I hereby certify that I attended the deceased from Oct 1946 to Mar 16 1947  
that I last saw her alive on Mar 16 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years About 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace Russia (City, town, or county) (State or foreign country)  
10. Usual occupation At home

Immediate cause of death Congestive Heart Failure Duration 6 mos  
Due to Rheumatic Heart Disease gro?  
Due to 93%  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy as above.

11. Industry or business \_\_\_\_\_  
12. Name Abraham Friedland  
13. Birthplace Russia (City, town, or county) (State or foreign country)  
14. Maiden name Annie Kasha  
15. Birthplace Russia (City, town, or county) (State or foreign country)  
16. (a) Informant Michael Shechtman  
(b) Address 709 Limit Avenue  
17. (a) Burial (b) Date thereof 3-18-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Olive Cemetery  
18. (a) Signature of funeral director [Signature]  
(b) Address 5216 Delmar Blvd  
19. (a) 3-20-47 (b) [Signature]  
(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) (e) Means of injury \_\_\_\_\_  
23. Signature Leigh Husella (M. D. or other) [Signature]  
Address 3726 Washington Date signed 3/17/47

(Licensed Embalmer's Statement on Reverse Side)

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

366

96  
21  
25

Duration  
6 mos  
gro?  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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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.P. 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.**