

S. No. 2
M-1/47
7. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 14 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15549**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4677**

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

1. PLACE OF DEATH:
(a) County.....**St. Louis**
(b) City or town.....**St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution.....**Jewish 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.....**96**
(c) City or town.....**University City** **NR3**
(If outside city or town limits, write "RURAL")
(d) Street No.....**6609 Kingsbury** **5**
(If rural, give location)
(e) Citizen of foreign country?.....**1** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME.....**BECKYE S. PRUSS**
3. (b) If veteran, name war.....
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **7**
year **1947** hour **7** minute **15** A.M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife.....**Boris Pruss** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased.....**Unknown**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb. 1944** to **May 7 1947**
that I last saw her alive on **May 6 1947**
and that death occurred on the date and hour stated above.
Duration

8. AGE: Years Months Days If less than one day
About 69 hr. min.

Immediate cause of death.....
Arteriosclerotic heart disease **4 yrs.**
Arteriosclerotic nephrosclerosis **4 yrs.**

9. Birthplace.....**St. Louis Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation.....**At home**

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

11. Industry or business.....
12. Name.....**Joseph Pruss**
13. Birthplace.....**Austria**
(City, town, or county) (State or foreign country)
14. Maiden name.....**Lizzie Levy**
15. Birthplace.....**Austria**
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....**Myocardial scars**
Granular kidneys

16. (a) Informant.....**S. L. Sessel**
(b) Address.....**559 N. SKinker Blvd.**
17. (a) **Burial** (b) Date thereof.....**5-9-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....**Mt. Olive Cem.**

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?..... (Specify type of place)
While at work?..... (e) Means of injury.....
Signature.....**Barrett S. Tausig** (M. D. or other) **MD**
Address.....**4540 Olive** Date signed.....**May 8**

18. (a) Signature of funeral director.....
(b) Address.....**5216 Delmar Blvd.**
19. (a) **MAY 8 1947** (b) **J. F. Bredeau**
(Date received local registrar) (Registrar's signature)

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.....

H. 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.