

FILED MAY 29 1947

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4995**

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

1. PLACE OF DEATH:

(a) County Jewett
(b) City or town St. Louis mo.
(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)
In this community 14 yrs years, months or days

3. (a) PRINT FULL NAME SYLVIA GOODMAN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
7. Birth date of deceased: _____ (Month) (Day) (Year)

8. AGE: _____ Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
about 65

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Moska Baer Paegman

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

14. Maiden name Sura Faga

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

16. (a) Informant Sam Goodman

(b) Address 7817 Cornell

17. (a) Burial (b) Date thereof May 18-47 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chapel Hill Emth

18. (a) Signature of funeral director Ex handles

(b) Address 5010 Enright

19. (a) MAY 18 1947 (b) J. F. Brede (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5911 Page Blvd. 9
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16 year 1947 hour 11 minute 20 P M.

21. I hereby certify that I attended the deceased from _____ 19 47 to death 19 _____
that I last saw her alive on May 16 and that death occurred on the date and hour stated above. 19 47

Immediate cause of death Cerebral Hemorrhage Duration 3 hrs.
Due to arteriosclerosis & hypertension
Due to _____

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) _____
(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 1

23. Signature Nelson B. Kerstner (Physician, D. or other) MD
Address 529 N. Grand Date signed May 18

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..... *Alex Campbell*
Licensed Embalmer No..... *3880*
P. O. Address..... *4355 Washington Ave*

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.