

No. 2
12-45
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 18 1947
Registration District No. **318**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

33025
State File No. _____
Registrar's No. **8588**

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

4. Sex Female **5. Color of race** White
6. (b) Name of husband or wife Skatoff Harry **6. (c) Age of husband or wife if alive** 9 66 years
7. Birth date of deceased July 9 1885
(Month) (Day) (Year)

8. AGE: Years 62 Months 2 Days 1 min. _____
If less than one day _____

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

10. Usual occupation HOUSEWIFE

11. Industry or business HOUSEWORK

12. Name ABRAHAM VERBAN

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

14. Maiden name LEAF FRYMER

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

16. (a) Informant Dora Mackay

(b) Address 5914 Hamilton Terr

17. (a) Burial Burial **(b) Date thereof** 9-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chyrah Kaduha

18. (a) Signature of funeral director Cherhandlin

(b) Address 5019 Eysart

19. (a) SEP 11 1947 **(b) J. G. Probst**
(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. 5606 Page 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day Sept 10
year 1947 hour _____ minute _____ a.m.

21. I hereby certify that I attended the deceased from July 1947 to Sept 9 1947
that I last saw her alive on Sept 9 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of
uterus
Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) H60

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) _____
(e) Means of injury _____ 0

23. Signature J. G. Probst (M. D. or other) _____

Address 4500 Olive Date signed 9-10-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

B. Alexander

Licensed Embalmer No.....

2669

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.