No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33119

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8647

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Masonic Home 5
(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)
In this community

2. USUAL RESIDENCE OF DECEASED: (?)
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
12
(d) Street No. Masonic Home 5321 Kingsbury
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ROSE WALLERSTEIN
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 Widow 2
6. (b) Name of husband or wife Lee Wallerstein
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 20 (Day) 1857 (Year)

8. AGE: Years	Months	Days	If less than one day
90	2	24	hr. min.

9. Birthplace (City, town, or county) Austria 4 (State or foreign country)
10. Usual occupation At home
11. Industry or business
FATHER 12. Name Unknown
FATHER 13. Birthplace (City, town, or county) Austria 1 (State or foreign country)
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace (City, town, or county) Austria 1 (State or foreign country)
16. (a) Informant Joseph Kohn
(b) Address 6675 Kingsbury
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-14-47 (Month) (Day) (Year)
(c) Place: burial or cremation Missouri Crematory
18. (a) Signature of funeral director Herman Kuehl Jr.
(b) Address 5216 Delmar Blvd.
19. (a) SEP 14 1947 (Date received by local registrar) (b) J. R. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 13th year 1947 hour 11 minute 15 A. M.
21. I hereby certify that I attended the deceased from July 21, 1947, to Sept. 13, 1947; that I last saw her alive on Sept. 13, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	3 days
Due to Chronic Myocarditis	6 mos.
Due to Senility	1 year
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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature [illegible] (M. D. or other)
Address 508 N. Grand Blvd. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....John Ketter.....

Licensed Embalmer No.....3880.....

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.