N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Buchanan

Township _____ or Village _____ or City St Joseph Mo (NO. 101 South 21st St St.: _____ Ward)

Registration District No. 85 — File No. 266

Primary Registration District No. 1001 — Registered No. 79

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Freda Safferstein

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: White — SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Jan (Month) 4 (Day) 1915 (Year)

AGE: ✓ yrs. 1 mos. 20 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): St Joseph Mo

PARENTS
NAME OF FATHER: Wm Safferstein
BIRTHPLACE OF FATHER (City or town, State or foreign country): Russia
MAIDEN NAME OF MOTHER: Jennie Malashock
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Russia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Safferstein

(ADDRESS) 101 South 21st St

Filed Jan 24 1915 W E Harrington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 24 (Day) 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 21, 1915, to Jan 23, 1915, that I last saw her alive on Jan 23, 1915, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

107 B

89

(Duration) ___ yrs. ___ mos. 3 ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Frederick G Lincoln M. D.

Jan 24th 1915 (Address) 720 Francis St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Shaare Sholem Cemt — DATE OF BURIAL: Jan 24 1915

UNDERTAKER: H. O. Sidenfaden — ADDRESS: 215 No. 10th St

Revised United States Standard Certificate

MISSOURI STATE BOARD OF HEA
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County

Township

or

Village

or

City (NO. St.: Ward)

Registration District No.

Primary Registration District No.

File No.

Registered No.

[If death occu hospital or in give its NAME of street and n

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) (Day)

I HEREBY CERTIFY, that I attended deceas

, 191 , to

that I last saw h alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos.

Contributory
(SECONDARY)

(Duration) yrs. mos.

(Signed)

191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Caus (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIE RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted if not at place of death?

Former or usual-residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS