LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

13114

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

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 3741

City St. Louis (No. Jewish Hosp St. ..... Ward)

2. FULL NAME Celia Falkoff

(a) Residence. No. ..... St., 12 Ward. East Prairie Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Julius Falkoff

6. DATE OF BIRTH (MONTH, DAY AND YEAR): unk

7. AGE: ab 55 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Wilna Russia

PARENTS

10. NAME OF FATHER: Michael ~~Unknown~~

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Russia

12. MAIDEN NAME OF MOTHER: unk.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Russia

14. INFORMANT: Julius Falkoff
(Address) E Prairie Mo

15. FILED APR 18 1927, 19 May C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 15 1927

17. I HEREBY CERTIFY, That I attended deceased from 2-10, 1927, to 4-15, 1927 that I last saw her alive on 4-15, 1927 and that death occurred, on the date stated above, at 9 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Liver
46 E
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY) 446
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? E. Prairie Mo

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2-18-27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic Exam

(Signed) Ernst Jonas, M. D

4-17, 1927 (Address) Lister Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bnai Amoona
DATE OF BURIAL: 4/19 1927

20. UNDERTAKER: H B Berger
ADDRESS: 4715 McPherson

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.

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