

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

Do not use this space.

34599

1. PLACE OF DEATH

County St. Louis County
 Township Central
 City St. Louis

Registration District No. 789
 Primary Registration District No. 6033
 (No. Jewish Sanatorium)

File No.
 Registered No. 9 09
 St. Ward)

2. FULL NAME

Mary Kaplan

(a) Residence. No. 297 Madison St. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Samuel Kaplan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 15-1899

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
28 10 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House 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) Russia

PARENTS

10. NAME OF FATHER Louis Bernstein

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

12. MAIDEN NAME OF MOTHER Esther

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

14. INFORMANT Samuel Kaplan
 (Address) 1907 Webster

15. FILED 11/28 1927 Walter Gray M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to November 28, 1927 that I last saw her alive on November 28, 1927, and that death occurred, on the date stated above, at 5:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac Failure and Toxemia

88 A 91 A
91 B

CONTRIBUTORY Bacterial Endocarditis
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, St. Louis Maternity Hospit.

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms and E.C.G.

(Signed) Selig Simon M.D.
11/28, 1927 (Address) 1117 S. 1st St. St. Louis, Mo.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Chesed Shel Emet

DATE OF BURIAL

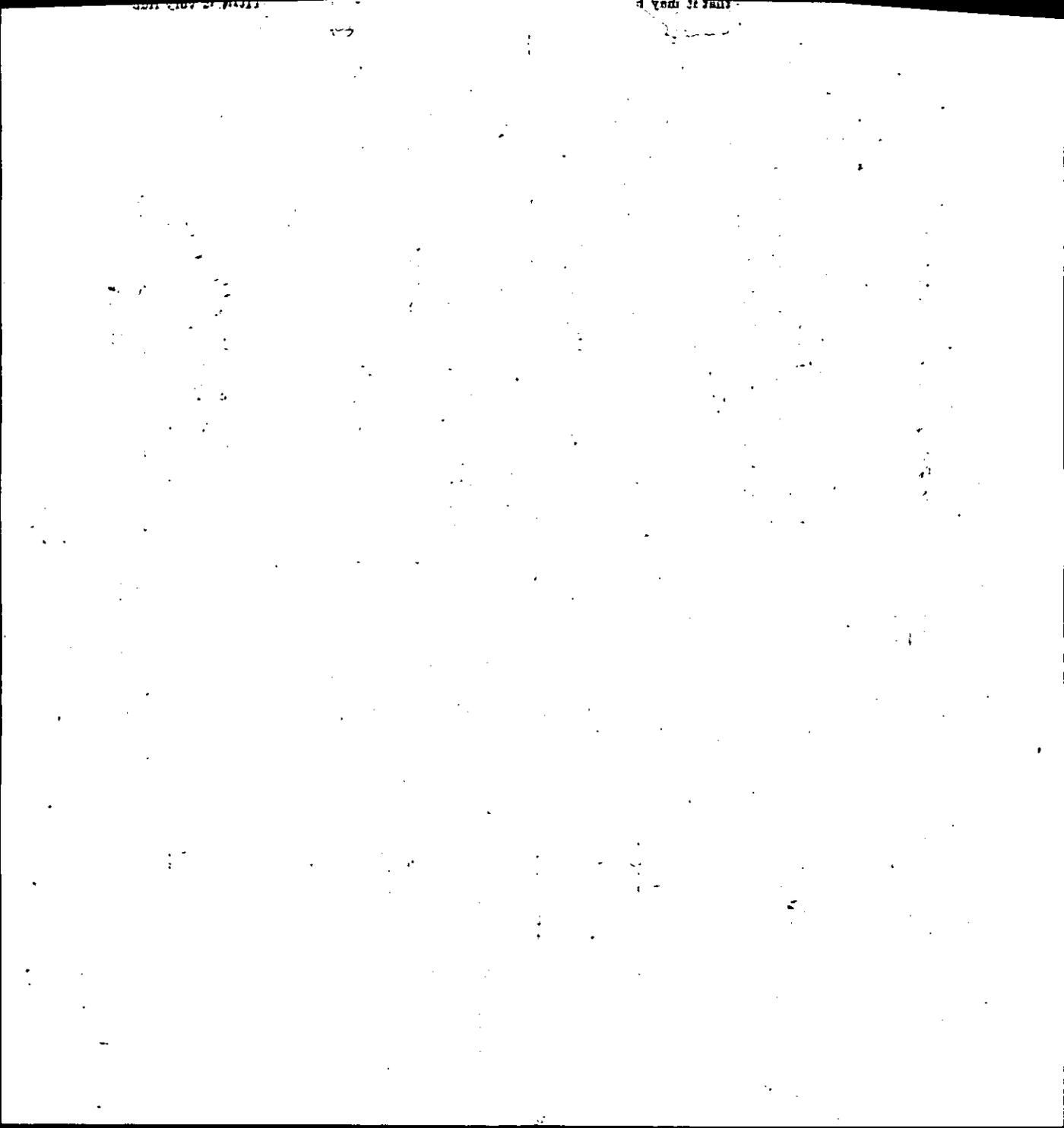
11-29 1927

20. UNDERTAKER

St. Hindskopf

ADDRESS

216 Belmont



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 789 File No. _____
 Township Central Primary Registration District No. 6023 Registered No. _____
 City _____ (No. Jewish Parish) St. _____ Ward _____

2. FULL NAME Mary Kaplan

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

16. DATE OF DEATH (MONTH, DAY AND YEAR) X 11-28 X 27

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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 _____

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)

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

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)

*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.

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

20. UNDERTAKER ADDRESS

14. INFORMANT _____
 (Address)

15. FILED 11/28 1927 Rolla Gray, M. D. REGISTRAR

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Exact statement of cause of death to be properly classified. Exact statement of cause of death to be properly classified.

5-34599