

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

Do not use this space.

35040

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. **791**
Primary Registration District No. **1003**
(Name) *Jewish Hospital*

File No.....
Registered No. **10189**
St. Ward)

2. FULL NAME

Eva Kleinman

(a) Residence. No. *4368 Evans Ave.* St. *11* Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

2. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 1 - 1910*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
17 1 13

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) *St. Louis*
(STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER *Leiser Kleinman*

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

12. MAIDEN NAME OF MOTHER *Bessie Lipshitz*

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

14. INFORMANT *Leiser Kleinman*
(Address) *4368 Evans Ave.*

15. FILED *24 2-1 1927* 19 *May B Starkoff*
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11/14 - 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 28* 19 *19* to *11/14* 19 *27* that I last saw her alive on *11/14* 19 *27* and that death occurred, on the date stated above, at *about 12:15 PM*

THE CAUSE OF DEATH** WAS AS FOLLOWS:
Respiratory failure from brain abscess? brain extra dural abscess? Brain abscess? ear 15 due to sup. P.C. right chronic abscess of the middle ear from infection

18. WHERE WAS DISEASE CONTRACTED *cause unknown*

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *Nov 3/27*

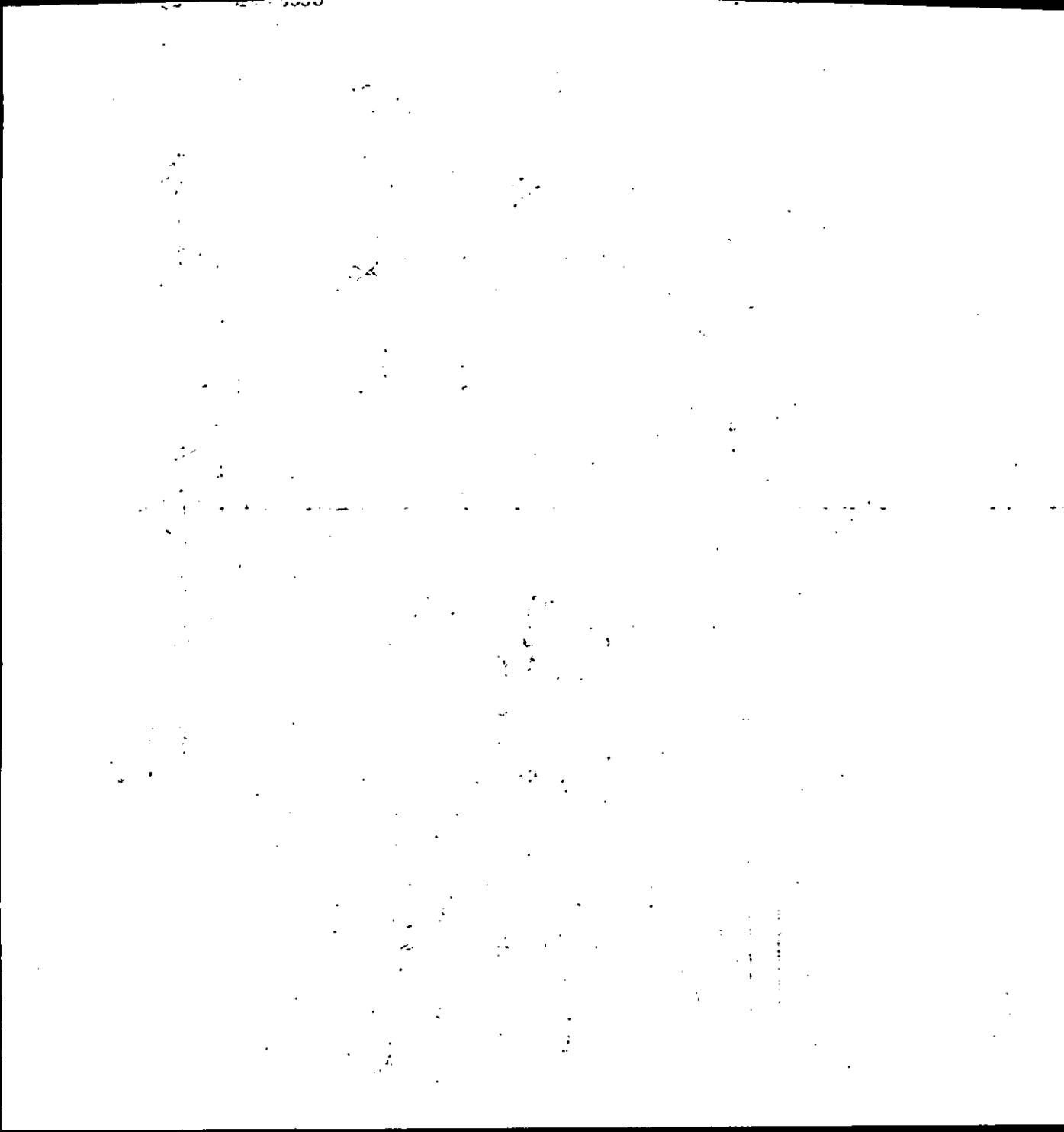
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS, *Operative disclosed extra dural abscess*
(Signed) *Jones K. Suggs* M. D.
, 19 (Address) *9000 Carleton Blvd*

*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 *Shesed Shel Emeth* DATE OF BURIAL *Nov. 15 - 1927*

20. UNDERTAKER *H. Rindorff* ADDRESS *5216 Delmar*



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ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 791 File No.....
 Township..... Primary Registration District No. 1003 Registered No. 10189
 City St. Louis (No.....) St. Ward.....

2. FULL NAME..... Eva. Kleiman
 (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 F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** S
(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)

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..... may 6 1927
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-14 1927

17. I HEREBY CERTIFY, That I attended deceased from 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:

Respiratory Failure from
Brain Abscess - Day Extra,
dural abscess - Brain abscess,
Otitis C. right ear (duration) 15 yrs. mos. ds.
abscess of the middle Ear from
infection cause unknown (duration) 7 mos. ds.

CONTRIBUTORY (SECONDARY).....

18. WHERE WAS DISEASE CONTRACTED.....

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE.....

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.

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

20. UNDERTAKER..... **ADDRESS**.....

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

SUPPLEMENTARY

S-35040