

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

Do not use this space.

35186

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. Jewish Hospital)

File No.....  
 Registered No. 10362  
 St. .... Ward)

**2. FULL NAME**

Eva Levin

(a) Residence. No. 6379<sup>a</sup> Clayton Ave. 4 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**

2. 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 Louis J. Levin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 15 - 1851

| 7. AGE | YEARS     | MONTHS   | DAYS     | IF LESS than 1 day, hrs. or min. |
|--------|-----------|----------|----------|----------------------------------|
|        | <u>66</u> | <u>3</u> | <u>2</u> |                                  |

**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) Russia  
 (STATE OR COUNTRY)

10. NAME OF FATHER Louis Adler

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

12. MAIDEN NAME OF MOTHER Anna Adler (nee)

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

14. INFORMANT Samuel A. Levin  
 (Address) 6379 Clayton Ave

15. FILED Nov 19 1927 May 6 Starkoff  
 1927 REGISTAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 17 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1927 to Nov 17 1927 that I last saw her alive on Nov 17 1927, and that death occurred, on the date stated above, at 12:30 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinoma of Cervix

CONTRIBUTOR (SECONDARY) Hipoc (duration) yrs. 6 mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, at home

DID AN OPERATION PRECEDE DEATH? yes DATE OF Nov 7

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Pathological Exam

(Signed) W. Klein, M. D.

, 19 (Address) 801 Braumal 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olive Jewish Cem. DATE OF BURIAL Nov. 20 1927

20. UNDERTAKER St. Rindskoff ADDRESS 5216 Delmar



**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. *791*  
 Township.....*St. Louis*..... Primary Registration District No. *1003*  
 City.....*St. Louis*..... St. .... Ward)

File No. *33-184*  
 Registered No. *10362*

**2. FULL NAME**

*Eva Lewin*

(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 (write the word) *m*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 13 / 1861*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*66 3 2*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration) ..... yrs. .... mos. .... ds.  
 (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. *APR -2 1925* FILED *max G Starkeoff* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 17 1927*

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:

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.  
 (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, OF HOMICIDAL.

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

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS 1, CP 3ED 3 AW

SUPPLEMENTARY

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