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

Do not use this space.

35507

File No. 10696

Registered No.

1. PLACE OF DEATH

County

Township

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

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Jennie Wolff Poslovsky

(a) Residence. No. 2217 Franklin St., N Ward. (If nonresident give city or town and State)
(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.

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: Morris Poslovsky

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

7. AGE: YEARS ab 45 | 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) Volhynia
(STATE OR COUNTRY) Russia

PARENTS

10. NAME OF FATHER: Haskell Barry

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

12. MAIDEN NAME OF MOTHER: Jessie unk

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

14. INFORMANT: Morris Poslovsky
(Address) 2217 Franklin

15. FILED NOV 29 1927, 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 28 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 23d 1927, 19..., to Nov 28, 1927, that I last saw her alive on Nov 28, 1927, and that death occurred, on the date stated above, at 2 45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia

7BA 1000 (duration) yrs. mos. 14 ds.

CONTRIBUTORY (SECONDARY) Brain Abscess (duration) due to infection cause unknown 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) Paul Murphy, M.D.

11/28, 1927 (Address) Jewish Hosp

*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: Hevre Kedisha

DATE OF BURIAL: 11/29 1927

20. UNDERTAKER: H B Berger

ADDRESS: 4715 McPherson

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

Township..... Primary Registration District No. 1003 Registered No. 10696

City St. Louis (No....., ...St. .....Ward)

2. FULL NAME Jennie W. Poslowsky

(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)
F	W	m

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..... Marie L. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 28 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:

.....
.....
.....
.....(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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—E[illegible] item of information [illegible] be cau[illegible] supplied [illegible] PHYSICIANS should [illegible] PERMANENT RECORD

RE[illegible] RARS SHALL NOT RECEIVE [illegible] FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-35507