

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

Do not use this space.

2791

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. Jewish Hospital) St. _____ Ward _____
 Registered No. **1 369**

2. FULL NAME Sarah Schneider

(a) Residence. No. 2130 Biddle St., 21 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 Rincar Schneider

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife
 (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 Emanuel Goodhalter

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

12. MAIDEN NAME OF MOTHER Ida Goodhalter (ne)

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

14. INFORMANT Rincar Schneider
 (Address) 2130 Biddle St.

15. FILED 1928 Mar. 6 Starkoff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 19 28
 17.

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1928, to Jan 10, 1928
 that I last saw h. & a. alive on Jan 10, 1928, and that death occurred, on the date stated above, at 10:14 p.m.

82A THE CAUSE OF DEATH* WAS AS FOLLOWS:
102
Cerebral Hemorrhage
Apoplexy
 (duration) _____ yrs. _____ mos. 7 da.

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

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Wm E. Taussig, M. D.

(Address) 3720 Washington

*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 Emeth Cem. DATE OF BURIAL Jan 11 1928

20. UNDERTAKER A. Rindskopf ADDRESS 5216
Delmar

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.

