

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.

37 1928

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

Do not use this space.

21754

1. PLACE OF DEATH
 County St. Louis Registration District No. 790
 Township Central Primary Registration District No. 6033
 City Clayton (No. 900) St. Mary St. _____ Ward _____
 2. FULL NAME Infant Lasersohn
 (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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17 28
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 0 0 0 7 7
 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) Liberty
 (STATE OR COUNTRY) _____
 10. NAME OF FATHER Abraham J. Lasersohn
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Russia
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Rose Hyman
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Russia
 (STATE OR COUNTRY) _____
 14. INFORMANT A. J. Lasersohn
 (Address) 900 St. Mary
 15. FILED June 19 28 Katharine W. Sullivan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18 1928
 17. I HEREBY CERTIFY, That I attended deceased from 11 PM June 17, 1928, to June 18, 1928, that I last saw him alive on June 18, 1928, and that death occurred, on the date stated above, at 6:15 p.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth
(7 months baby)
159 (duration) yrs. mos. ds.
 CONTRIBUTORY None (SECONDARY) (duration) yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED 161st
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) Dr. J. J. McPherson M. D.
6/18, 1928 (Address) 1515 E. 16th St.
 *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 Shelburne DATE OF BURIAL 6/18 1928
 20. UNDERTAKER H. D. Berger ADDRESS 4715 McPherson

