

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 481
Township..... Primary Registration District No. 202
City St. Louis (No. Mr Baptist)

File No. 25246
Registered No. 7048
St. Ward)

2. FULL NAME

Mr Anna Galitsky
(a) Residence. No. 2843 Thomas St., W 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.

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 Samuel Galitsky
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/11/1928
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
at 60

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 Israel Gross

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

12. MAIDEN NAME OF MOTHER Leonia Duse

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

14. INFORMANT S. Galitsky, 1165
(Address) 2843 Thomas

15. FILED 11-6-1928 Mar C. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7.6. 1928
17.

I HEREBY CERTIFY That I attended deceased from 7.5. 1928 to 7.6. 1928
that I last saw h. l. a. alive on 7.6. 1928, and that death occurred, on the date stated above, at 10:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Central apoplexy
822
97
48 hours
(duration) yrs. mos. ds.

CONTRIBUTORY Arterial degeneration
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No

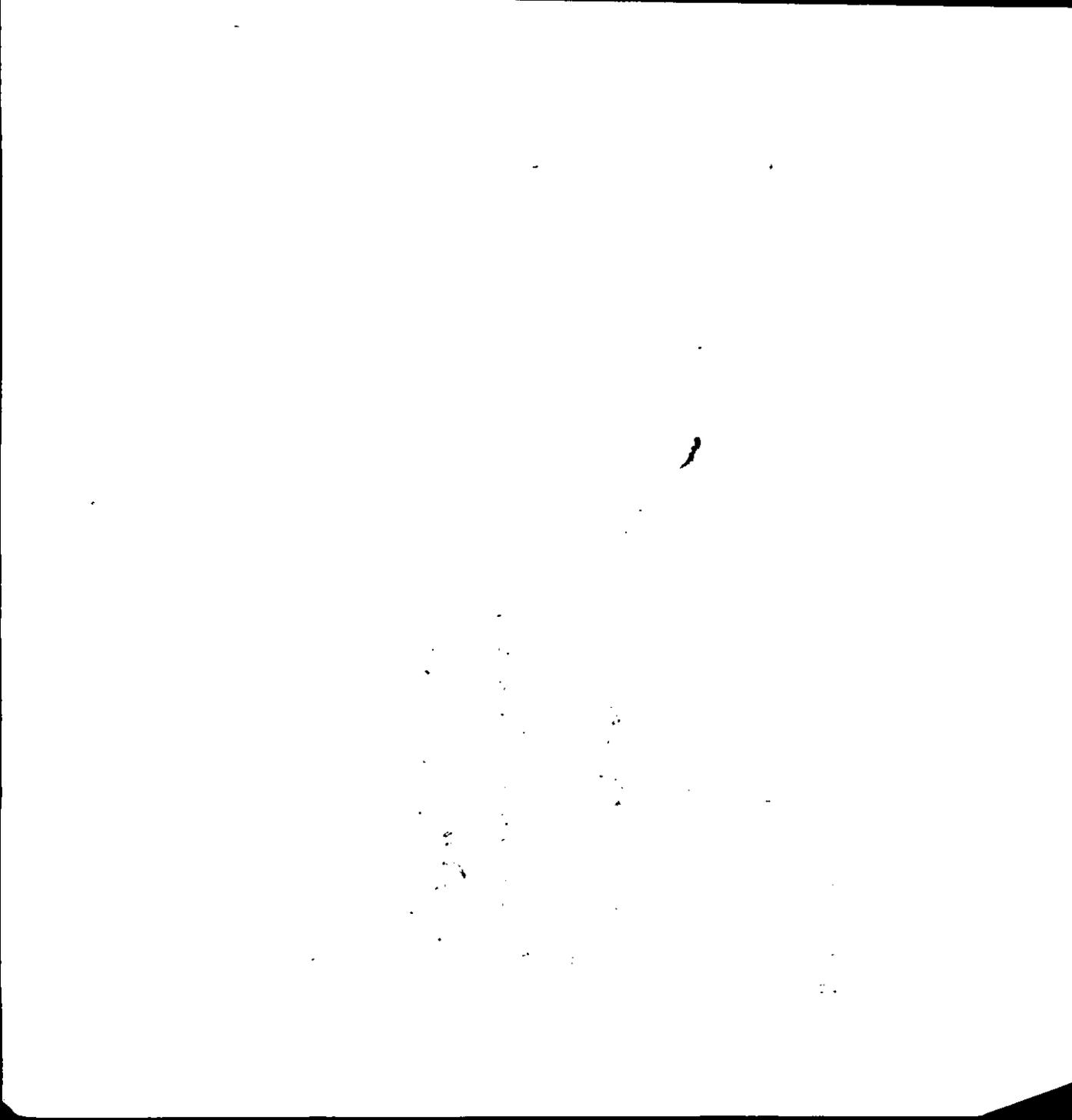
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Frank P. Fry, M.D.

7.6. 1928 (Address) 2720 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 Levee Cemetery
DATE OF BURIAL 7/6 1928

20. UNDERTAKER H. B. R. Meyer 4715
ADDRESS Wetherburn



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... (No. St. Ward) Registered No. 7046

2. FULL NAME

Fannie Galitsky

(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. da. 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)

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 *Miss Berger*
(Address) *4715 Madison*

15. FILED *19 15 15* *Miss O. Starkey*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 6* 19 *48*

17. I HEREBY CERTIFY That I attended deceased from 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.

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

REPRODUCED FROM ORIGINALS UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-25246