

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

Do not use this space.

1. PLACE OF DEATH

County.....
Towship.....
City.....

Registration District No. **781**
1003
Primary Registration District No.

File No. **25413**
Registered No. **7225**
St. Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** female
4. **COLOR OR RACE** white
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) widow

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

6. **DATE OF BIRTH (MONTH, DAY AND YEAR)** 1-26-1881

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	47	5	14	

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)** *ghetomor*
(STATE OR COUNTRY)

10. **NAME OF FATHER** Abraham Chula Mallos

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

12. **MAIDEN NAME OF MOTHER** *Estimide (unk)*

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

14. **INFORMANT** *Dave Sherman*
(Address) *5720 Theodora*

15. **FILED** 11 1928 *Max C Starckoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH (MONTH, DAY AND YEAR)** *July 10* 1928

17. **I HEREBY CERTIFY** that I attended deceased from *July 6* 1928 to *July 10* 1928 that I last saw him alive on *July 10* 1928, and that death occurred, on the date stated above, at *2:30* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
Apoplexy
82/3
102 (duration) yrs. mos. ds. *6*

CONTRIBUTORY (SECONDARY) *Hypertension*
(duration) *6* mos. ds.

18. **WHERE WAS DISEASE CONTRACTED** *7401*
IF NOT AT PLACE OF DEATH.....

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

WHAT TEST CONFIRMED DIAGNOSIS *Phys Ex only*
(Signed) *Colon Caperson* M. D.
(Address) *Metropolitan 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** *David Abel Smith*
DATE OF BURIAL *9/11* 1928

20. **UNDERTAKER** *H B Berger*
ADDRESS *4715 W Sherman*

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.

PERMANENT RECORD

Metropolitan Bldg.