

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

Do not use this space.

38290

1. PLACE OF DEATH

County.....

Registration District No. *7011*

Township.....

Primary Registration District No. *1003*

City *St. Louis* (No. *Jewish Hospital*)

File No.

Registered No. *10893*

St. Ward

2. FULL NAME *MATTIE GOLDSMITH*

(a) Residence. No. *6645 University Drive 14* Ward. *St. Louis 00. 7th*

(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) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *David Goldsmith*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 25 - 1864*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>63</i>	<i>11</i>	<i>11</i>	

8. OCCUPATION OF DECEASED *131 At home 92C*
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer) *82A*
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo.*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Adolph Loth*

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

12. MAIDEN NAME OF MOTHER *Sarah Popper*

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

14. INFORMANT *David Goldsmith*
 (Address) *6645 University Drive*

15. FILED *NOV 27 1928* *May C. Starke* REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov. 6 1928*

17. I HEREBY CERTIFY, That I attended deceased from 1928 to *Nov. 6*, 1928 that I last saw him alive on *Nov. 6*, 1928, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: *10 A. Embolus cerebral Edema of brain*

CONTRIBUTORY (SECONDARY) *non tubercular Arthma bronchial - Nephritis chronic (arterio-sclerotic) Hypertension*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Hewell Sale*, M. D. *11/7*, 1928 (Address) *3720 North 7th*

*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 *Mt. Sinai Cemetery* DATE OF BURIAL *Nov - 8 1928*

20. UNDERTAKER *H. Rindskopf* ADDRESS *5216 Selmer*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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