

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

Do not use this space.

12891

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **City / Report**)

File No.....
 Registered No. **3441**
 St. Ward)

2. FULL NAME

(a) Residence. No. **2516 St. Ferdinand** **11** Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **50** 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** *Widowed*
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
abt. 76

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) *Russia*

PARENTS

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT (Address) *St. Louis Hospital*

15. FILED 19 *1929* **REGISTRAR** *W. C. Barker*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 19 1929*

17.

I HEREBY CERTIFY That I attended deceased from *March 19 1929* to *March 19 1929* that I last saw him alive on *March 19 1929* and that death occurred, on the date stated above, at *11:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
92% Endocarditis
16% (duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *None* (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *None*

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *R Berg* (Signed)....., M. D.

3/19/29 (Address) *City / Report*

*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 *Closed Shell Cemetery* **DATE OF BURIAL** *3/20/ 1929*

20. UNDERTAKER *H. B. Bremer* **ADDRESS** *475 Maple*

Kosenuka

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No.....
Towship..... Primary Registration District No.....
City..... (No.....).....

File No. 3441
Registered No. 3441
St. Ward)

2. FULL NAME

Sarah J. Rosenthal
4516 N. Ferdinand

(a) Residence. No. 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 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.
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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 *U Isaac Rosenthal*
(Address) *4369 Lee Ave*

15. FILED *Jul 12 1929* *Max C. Stalder*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 19 1929*

17. I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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