

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

Do not use this space.

16565

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... **St. Louis** Primary Registration District No. **2003**  
 City..... **St. Louis** (In **City Hospital**)

File No.....  
 Registered No. **4657**  
 St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **922 N. 113** St., **23** 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 **male** | 4. COLOR OR RACE **white** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **widower**

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
**Abt 70**

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work **Retail Dry goods**  
 (b) General nature of industry, business, or establishment in which employed (or employer) **Retired**  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Russia**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **do**

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

14. INFORMANT (Address) **Joe Epstein 1223 4905 Ashrove**

15. FILED **22 1929** **Mar C Starkey** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Apr 21 1929**

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19..... that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at..... 11 P..... m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

**Chronic Myocarditis**  
**930**  
 (duration)..... yrs..... mos..... ds.

CONTRIBUTOR (SECONDARY) **90 B**  
 (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? **No**

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) **J. J. Hurley**, M.D.  
**4 23**, 19 **29** (Address) **Deputy Coroner**

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Bnei Amoona** DATE OF BURIAL **4/24 1929**

20. UNDERTAKER **H. B. Berger** ADDRESS **415 McPherson**

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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