

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

Do not use this space.

26430

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **Jewish** **Moyp**)

File No.
Registered No. **7685**
St. Ward)

2. FULL NAME

(a) Residence, No. **5720** **habanne** St. **12** Ward. (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 **Bernard L. Isaacs**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **12-27-1883**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,
	45	6	27	hrs. or

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)

(STATE OR COUNTRY) **Russia**

10. NAME OF FATHER **Mendel Klugman**

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

12. MAIDEN NAME OF MOTHER **Rachel Klugman**

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

14. INFORMANT (Address) **St. Berger 4715 McCheson**

15. FILED **1 27 1914** **Karl C. Stuber** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 24 1929**

17. I HEREBY CERTIFY, That I attended deceased from **July 20 1929** to **July 24 1929** that I last saw him alive on **July 24 1929**, and that death occurred, on the date stated above, at **1 00** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute yellow atrophy of the liver
12.5 (duration) yrs. mos. **5** ds.
12.4
CONTRIBUTORY **Cirrhosis of the liver** (SECONDARY) (duration) **1** yrs. mos. ds.

18. WHETHER DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Albert E. Tamm** M. D.
7/25 1929 (Address) **3720 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

Resed Stel Emeth DATE OF BURIAL **7/26 1929**

20. UNDERTAKER

St. Berger ADDRESS **4715 McCheson**

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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