

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

Do not use this space.

31970

**1. PLACE OF DEATH**

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

File No.....  
Registered No. **8999**

**2. FULL NAME**

(a) Residence No. .... St. **12** Ward. **Steubenville Ohio**  
(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) married  
**6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**  
**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) **unk**  
**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**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) **Hungary**  
(STATE OR COUNTRY)  
**10. NAME OF FATHER** **Frank Kaufman**  
**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) **Hungary**  
(STATE OR COUNTRY)  
**12. MAIDEN NAME OF MOTHER** **unk**  
**13. BIRTHPLACE OF MOTHER** (CITY OR TOWN) **Hungary**  
(STATE OR COUNTRY)

**14. INFORMANT** **A. Buderman**  
(Address) **Steubenville Ohio**  
**15. FILED** **May 6 1929** **May E. Starckoff**  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) **Sept 5 1929**  
**17. I HEREBY CERTIFY, That I attended deceased from** **May 1 1929**, to **Sept 5 1929**, that I last saw him alive on **Sept 5 1929**, and that death occurred, on the date stated above, at **3:30 p.m.**  
**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
**Tumor of Brain - Malignant**  
**44 875**  
(duration) ..... yrs. .... mos. .... ds.  
**CONTRIBUTOR (SECONDARY)** **Crematory**  
(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**  
IF NOT AT PLACE OF DEATH.....  
**19. DID AN OPERATION PRECEDE DEATH?** **Yes** DATE OF **9/6/29**  
**20. WAS THERE AN AUTOPSY?** **Yes**  
**WHAT TEST CONFIRMED DIAGNOSIS?**  
(Signed) **Robert M. Klumpp**, M. D.  
**9/6 1929** (Address) **579 University Club 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** **Beth Ham Hag** **DATE OF BURIAL** **9/6 1929**  
**20. UNDERTAKER** **H. B. Berger** **ADDRESS** **4159 McPherson**

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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