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

Do not use this space.

35120

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. .....

Township Gondelet ..... Primary Registration District No. ..... Registered No. 9843

City St Louis Mo ..... (No. ..... St. ..... Ward)

2. FULL NAME Sarah Rebbca MELLMAN

(a) Residence. No. 7523 S Broadway St., 1 Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Late Chaim Ersh-MELLMAN.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown abt 1852

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt 77		unknown	unknown	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

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

PARENTS

10. NAME OF FATHER Nathan Koppelman

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

12. MAIDEN NAME OF MOTHER Sarah Rebbca Koppelman Nee

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

14. INFORMANT Jacob Mellman
(Address) 1396 Arlington ave.

15. FILED OCT -6 1929 Max C. Starkloff REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-5- 1929.

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Oct 5, 1929, that I last saw her alive on Oct 5, 1929, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. myocarditis
Diabetes mellitus.
59
93c

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 5/

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? physical & lab.

(Signed) J. Kopelowitz, M. D

10-6-, 1929 (Address) Mo. 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	DATE OF BURIAL
Chesd Shel Emeth	Oct 7 - 1929

20. UNDERTAKER	ADDRESS
Renhandler Undertaker	4822 Easton Av

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.