

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

Do not use this space.

35847

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. **791**

Primary Registration District No. **1003**

File No.
Registered No. **10650**
St. Ward)

2. FULL NAME

(a) Residence, No. *A. Leib Grosberg* St. *11* Ward *11*
(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 *male* 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 *Anna Grosberg*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *unknown*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
ab 68

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer). *coffee mach*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Russia*

10. NAME OF FATHER *David M. Grosberg*

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

12. MARRIED NAME OF MOTHER *Griedlander*

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

14. INFORMANT *M. J. Grosberg*
(Address) *1323 Clark*

15. FILED *OT 29 1929* *Ray C. McKinley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 28 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 28*, 1929, to *Oct 28*, 1929, that I last saw him alive on *Oct 28*, 1929, and that death occurred, on the date stated above, at *8:15* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

160 Pulmonary oskema non Tubercular
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Scartity + Mitral Insufficiency*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH

8. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *M. J. Grosberg* M. D.

10/29, 1929 (Address) *4103 Eastus*

*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

Beth Ham Bag *10/30 1929*

20. UNDERTAKER ADDRESS

160 Berger *4815 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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