

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

Do not use this space.

14799

1. PLACE OF DEATH

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

Registration District No. *791*

Primary Registration District No. *1003*

File No.....
Registered No. *4209*..
St..... Ward.....

2. FULL NAME

(a) Residence. No. *1438 E Grand* St., *9* 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

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

Lazar Goldman

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

June 30, 1866

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

63 | *9* | *25*

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)

Kovno Russia

10. NAME OF FATHER

Hyman Kamker

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

Russia

12. MAIDEN NAME OF MOTHER

pink

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

Russia

14. INFORMANT

W. H. Goldman

(Address) *786 Hermann*

15. FILED

46 26 1930

W. H. Goldman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Apr 25 1930

17. I HEREBY CERTIFY, that I attended deceased from *4/25/30* to *4/25/30*, 19*30*, that I last saw her *alive* on *4/25/30*, 19*30*, and that death occurred, on the date stated above, at *11:25 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Myocarditis
Hypertension & arteriosclerosis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Pulmonary Edema

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

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

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *J. H. A. Kouch* M. D.
4/25, 1930 (Address) *Resident Jewish Hospital*

*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

4/27 1930

20. UNDERTAKER

H. B. Berger

ADDRESS

4715 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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