

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

Do not use this space.

20816 ~~20014~~

**1. PLACE OF DEATH**

County..... Registration District No. 701  
Township..... Primary Registration District No. 1003  
City St. Louis (No. St. John's)

File No. ....  
Registered No. 5614.  
St. .... Ward

**2. FULL NAME**

(a) Residence. No. 6314 Enright St. 12 Ward St. Louis Co. Mo  
(Usual place of abode) (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 <u>female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov 15 1867</u>		
7. AGE	YEARS <u>62</u>	MONTHS <u>6</u>
	DAYS <u>29</u>	If LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at home</u> (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) <u>Perakow Austria</u>		
PARENTS	10. NAME OF FATHER <u>Juda L. Greender</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN). (STATE OR COUNTRY) <u>Austria</u>	
	12. MAIDEN NAME OF MOTHER <u>Libbie Haifman</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN). (STATE OR COUNTRY) <u>Austria</u>	
14. INFORMANT. (Address) <u>Morris F. Marko</u> <u>720 Limbo</u>	15. FILED <u>NOV 10 1933</u> <u>W. E. Storker</u> REGISTRAR	

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1930  
17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 10, 1930. that I last saw h. alive on June 9, 1930, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Diabetes Mellitus & amputation of left lower limb due to diabetic gangrene  
(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) 57  
(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH? yes DATE OF 5-26-30  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Lab. Tests  
(Signed) Robert Keyland, M. D.  
6/10, 1930 (Address) 5901 Park Ave

\*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  
Bnai Anama  
DATE OF BURIAL  
6/17 1930  
20. UNDERTAKER  
W. 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.

