34794
Do not use this space.

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

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

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

File No. ..... Registered No. 10186

2. FULL NAME Mandell Gladstein

(a) Residence. No. 1422 S. 14th St., 75 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U.S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dora Gladstein

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10 1873

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
56	10	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Jeller
(b) General nature of industry, business, or establishment in which employed (or employer) Merchandise
(c) Name of employer His Own

9. BIRTHPLACE (CITY OR TOWN) Lodz
(STATE OR COUNTRY) Poland

PARENTS

10. NAME OF FATHER Ehrmandicha Gladstein

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

12. MAIDEN NAME OF MOTHER Sarah Zittel

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

14. INFORMANT Wm Gladstein
(Address) 1422 S 2nd St

15. FILED OCT 27 1930 Max C Starkloff
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 26 1930

17. No Physician in Attendance
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3.50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Haemorrhage & Shock due to Stab Wound Left Lung Jugular Vein Knife (duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. W. Lemen M.D.
10/27 1930 (Address) Dep-Coroner

*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
Chesed Shel Emeth	Oct 27 1930
20. UNDERTAKER	**ADDRESS**
Shukandler	4622 Eichen

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD