

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

File No. **7179**
Registered No. **1486**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **701**
Township _____ Primary Registration District No. **1000**
City **St. Louis** (No. **Gen. Sh. Hosp.**)

2. FULL NAME

(a) Residence. No. **5260 Vernon** St., **12** Ward.
(Usual place of abode)
Length of residence in city or town where death occurred **20** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 4 - 1898**

7. AGE YEARS MONTHS DAY If LESS than 1 day, _____ hrs. or _____ min.
32 **7** **0**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Stenographer**
(b) General nature of industry, business, or establishment in which employed (or employer) **254**
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Chicago, Ill.**

PARENTS
10. NAME OF FATHER **Jacob Wolkowitz**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Poland**
12. MAIDEN NAME OF MOTHER **Bessie Levinson**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Russia**

14. INFORMANT **George Wolkowitz**
(Address) **5260 Vernon Ave**

15. FILED **-6 1931** **Wm. C. Starker** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb 4 1931**

17. I HEREBY CERTIFY, That I attended deceased from **10:30 A.M. of 2/4**, 19**31**, to **9:50 P.M. to 2/5**, 19**31**, that I last saw h. **at** alive on **2/4**, 19**31** and that death occurred, on the date stated above, at **10:30** p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza.
Pneumonia
11A
107B
(duration) yrs. mos. **10** ds.

CONTRIBUTORY (SECONDARY) **11A**
(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) **M. J. Goldenson**, M. D.
, 19 (Address) **Metropolitan 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 **B'hai Amoona** DATE OF BURIAL **2-5 1931**

20. UNDERTAKER **H.B. Berger** ADDRESS **4710 1/2 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.

