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.

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

Do not use this space.

File No. 15656
Registered No. 4092

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St. Louis (No. Jewish Hospital St. ..... Ward)

2. FULL NAME Madeline Gross

(a) Residence. No. 5395 Pershing Ave. St., 12 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. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles S. Gross

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 1, 1889

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	41	6	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home 235
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) New York
(STATE OR COUNTRY) N.Y. ?

PARENTS
10. NAME OF FATHER Benjamin Sachs
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Russia 23
12. MAIDEN NAME OF MOTHER Amelia Wolf
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Russia

14. INFORMANT Char. S. Gross
(Address) 5359 Pershing Ave.

15. FILED ..... 19 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/2 1931

17. I HEREBY CERTIFY, That I attended deceased from 2/28, 1931, to 4/2, 1931, that I last saw h. e. alive on 4/2, 1931 and that death occurred, on the date stated above, at 1:26 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Agranulocytic Angina
115A 150
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (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? yes.
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Julius Elias, M. D.
4/2, 1931 (Address) 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
Mt. Olive Jewish Cemetery	April 5 1931
20. UNDERTAKER	**ADDRESS**
H. Rindskopf	5216 Delmar