

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

Do not use this space.

30214

1. PLACE OF DEATH

96 County St. Louis Registration District No. 784
Township St. Ferdinand Primary Registration District No. 6030
City Robertson, Mo. (No. Fourth Sanitation)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2018 Dickson Street St. Louis, Mo. Ward _____
(Usual place of abode)
(If nonresident, give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) September 14, 1910

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
22 4

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) 355
(c) Name of employer Sorenfeld

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

PARENTS
10. NAME OF FATHER Isadore Chotinsky
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Russia
12. MAIDEN NAME OF MOTHER Anna Yovich
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Russia

14. INFORMANT Michael Kovack
(Address) 5325 Ridge

15. FILED 15/4 1932 Ed Harris
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) September 8 1932

17. I HEREBY CERTIFY, That I attended deceased from December 8, 1927, to September 8, 1932 that I last saw him alive on September 8, 1932, and that death occurred, on the date stated above, at 8:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

231 Pulmonary tuberculosis (duration) 5 yrs. mos. ds.
23 Contributory (SECONDARY) Laryngeal tuberculosis (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (1)
IF NOT AT PLACE OF DEATH _____

9 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical and laboratory
(Signed) Galy Simon per D. Kuttner M.D.

7-8 1932 (Address) Female Sanatorium, Robertson, Mo.

*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 Chesed Shel Emet DATE OF BURIAL Sept 9 1932

20. UNDERTAKER Oxenhander Funeral Directors ADDRESS 4769 Washington

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.

100-29-1932

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1895
R. J. B. V.

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