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.

REC'D MAR 13 1939

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

791
1003

4675
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 1
(b) Township ..... Primary Registration District No. ..... Registered No. 1368
(c) or City St. Louis (d) Street No. Jewish Hosp St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 200 Mollie Lasky
(a) Residence, No. 5883 Enright St. 5
(Usual place of abode, if no street address, write county or city) (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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Arthur Lasky

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): April 15, 1903

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
35	9	25	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Omaha Nebraska

FATHER
13. NAME: Samuel Waxman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): U.S.S.R.

MOTHER
15. MAIDEN NAME: Rose Goodman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Czecho Slovackia

17. INFORMANT (ADDRESS): A. Lasky 5883 Enright

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Olive Heb. DATE 2/12, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS): H.B. Berger 4715 McPherson

20. FILED FEB 12 1939 J. F. Bridek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 10, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1939, to Feb 10, 1939
I last saw her alive on Feb 9, 1939. Death is said to have occurred on the date stated above, at 2:45 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Status Asthmaticus	2-8-39
107a	
Other contributory causes of importance:	
Terminal Pneumonia Bronchial	2-9-39

Name of operation — Date of
What test confirmed diagnosis? — Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Lawrence E. Friedman, M. D.
(Address) 4500 Olive

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

H. I. Berger, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 1597

P. O. Address 4715 McPherson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.