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.

DEC'D MAR 13 1939

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

5121
Do not use this space.

791

1. PLACE OF DEATH
(a) County
(b) Township
(c) City St. Louis
Registration District No. 1003
Primary Registration District No.
Registered No. 1814
(d) Street No. Children's Hospital 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 145 CARROLL KAPLAN
(a) Residence, No. 4212 Lafayette Ave. St. 17
(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): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 10, 1934.
7. AGE: YEARS 5 | MONTHS — | DAYS 14 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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) St. Louis, Mo.

FATHER
13. NAME Ben Kaplan
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

MOTHER
15. MAIDEN NAME Freida Grosberg
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) East St. Louis, Ill

17. INFORMANT (ADDRESS) Ben Kaplan 4212 Lafayette
18. BURIAL, CREMATION, OR REMOVAL PLACE Beth Hamerrosh DATE 2-26 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. Rindskopf 5216 Delmar
20. FILED FEB 25 1939 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1939, to Feb. 24, 1939
I last saw her alive on Feb. 24, 1939. Death is said to have occurred on the date stated above, at 11 05 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute laryngo-tracheo-bronchitis non diphtheretic	

Other contributory causes of importance: 106a

Name of operation Tracheotomy Date of Feb. 23, '39
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?
If so, specify
(Signed) Park J. White, M. D.
(Address) 3720 Washington St. Louis

(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 .....

Registered Apprentice No....., working under my personal supervision.

Signed C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address.....

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

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