

13 1939  
 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 9 1939

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

7742  
 Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784  
 (b) Township 1 Primary Registration District No. 101  
 (c) City Clayton (d) Street No. 7545 Oxford Dr. 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

556 Julie Kaminer  
 (a) Residence, No. 7545 Oxford St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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 Harry J. Kaminer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 21, 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
52 5 20

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. At Home  
 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 Leo Mathes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Kate Hartman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

17. INFORMANT (ADDRESS) Harry Kaminer 7545 Oxford Dr.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Sinai Cem. DATE Feb. 14, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Herman Rindfleisch 5216 Delmar Blvd.

20. FILED FEB 13 1939 110 R Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1939, to Feb 12, 1939  
 I last saw her alive on Feb 12, 1939. Death is said to have occurred on the date stated above, at 12:30 a.m.  
 The principal cause of death and related causes of importance were as follows:

Sub bacterial endocarditis Date of onset Nov 29  
95 C  
 Other contributory causes of importance:  
Rheumies, Heart disease 30 yr

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Culture 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) A. M. Grant M. D.  
 (Address) 3651 Grandway

**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

*Charles Cooper*

Licensed Embalmer No.

*13830*

P. O. Address

*15216 Delmar*

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

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