

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.

REGD SEP 14 1939 **791**

Registration District No. **1003**

Primary Registration District No. _____

Registrar's No. **6849**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
 (b) City or town St. Louis, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Jewish Hospital
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 4 days
 (Specify whether years, months or days)
 In this community 26 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1
 (c) City or town St. Louis [6]
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1970 Goodfellow
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 26 ? years.

3. (a) PRINT FULL NAME BESSIE WEITZMAN 325

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife JOSEPH Joseph Weitzman 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased 27 Nov - 1895
 (Month) (Day) (Year)

8. AGE: Years 44 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace KAMENETZ PODOLSK Russia
 (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name BEN KODNER

13. Birthplace Russia
 (City, town, or county) (State or foreign country)

14. Maiden name YETTA SILVERSTEIN

15. Birthplace Russia
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature JOSEPH WEITZMAN

(b) Address 1410 GOODFELLOW

17. (a) BURIAL (b) Date thereof 8 7 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CHESED SHEL EMETH

18. (a) Signature of funeral director H. B. BERGER

(b) Address 4715 McPHERSON

19. (a) AUG 7 1939 (b) J. Budick
 (Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 6
 year 1939 hour 7:30 PM minute _____ M.

21. I hereby certify that I attended the deceased from Aug 2, 1939, to Aug 6, 1939
 that I last saw her alive on August 6, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Crisipelas of rt leg. & thigh
 Duration 1 week

Due to Rheumatoid dis. ?
nitral strom

Due to Cardiac Failure 6 yrs.
 Other conditions Renal failure
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy 720

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature R. J. Trochman M.D. (M. D. or other)
 Address Jewish Hospital Date signed 8/6/39

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.....



Licensed Embalmer No. 1597

P. O. Address.....

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.