

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41646

Registration District No. 701

Primary Registration District No.

Registrar's No. 10769

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 28 yrs.
years, months or days)

3. (a) PRINT FULL NAME Pessie Nissenholtz 254

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

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

6. (b) Name of husband or wife. Philip Nissenholtz 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. (unk)
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
ab. 69 hr. min.

9. Birthplace Volhynia U.S.S.R.
(City, town, or county) (State or foreign country)

10. Usual occupation at home 7

11. Industry or business _____

MOTHER FATHER { 12. Name Isaiah Siralyus 7

13. Birthplace _____ U.S.S.R.
(City, town, or county) (State or foreign country)

14. Maiden name Rachel (unk)

15. Birthplace _____ U.S.S.R.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Max Nissenholtz

(b) Address Wood River Ill.

17. (a) burial (b) Date thereof 12/18/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bevra Kedisha

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

(b) Address 4715 McPherson

19. (a) DEC 18 1939 (b) J. H. Berger
(Date received for registration) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 5
(If outside city or town limits, write "RURAL")
(d) Street No. 5800 Parshing
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 28 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 17
year 1939 hour 4 minute 30 A.-M.

21. I hereby certify that I attended the deceased from Dec-1-
1939, to December-17, 1939;

that I last saw her alive on Dec-16-, 1939;

and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Haemorrhage Duration _____

Due to Myocardium

Due to Myocarditis Chronic

Other conditions cardio renal disease
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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)
(a) Means of injury _____

23. Signature J. H. Berger (PROBSTEIN) (M. D. or other)

Address John Berger Date signed 12/17/39

STATE OF MISSOURI
DEPARTMENT OF HEALTH

Proctor

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.....

..... **Herbert I. Berger**, Registered Apprentice No.....
working under my personal supervision. 4715 McPHERSON AVE.
ST. LOUIS, MO.

Signed..... *Herbert I. Berger*

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.