

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9216
Registrar's No. 2699

Registration District No. 791

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Lukes
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 18 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis 12
(If outside city or town limits, write "RURAL")
(d) Street No. 4604 Newberry Terr
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 28 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month March day 21
year 1940 hour 10 pm minute _____ M.

21. I hereby certify that I attended the deceased from Dec 1 - 1939
_____ 19____, to March 1, 1940
that I last saw her alive on March 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction Duration 1/2 hr.
failure

Due to Hypertension Head Disease card y.
Hypertension

Due to Hypertension card y.

Other conditions Arteriosclerosis + Obesity card y.
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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

8. (a) PRINT FULL NAME PEARL L. BOYITZ

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Late Max Leibowitz 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years abr 58 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Housework

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Martha Stone

(b) Address 6261 Clemens

17. (a) Burial (b) Date thereof March 22 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chapel Hill Cemetery

18. (a) Signature of funeral director Chapman

(b) Address 4469 Washington

19. (a) MAR 22 1940 (b) J. F. [Signature]
(Date received local registrar) (Registrar's signature)

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 Dr. J. Tenturia (M. D. or other) _____
Address 3903 Olive St. Date signed 3/22/40

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.....

myself
.....
working under my personal supervision.

....., Registered Apprentice No.

Signed *W. J. Henkander*
.....

Licensed Embalmer No. *3669*
.....

P. O. Address *4469 Washington*
.....

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.