

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 St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Josephine Berkamp Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 35 yrs. (Specify whether years, months or days)  
In this community 35 yrs.

3. (a) PRINT FULL NAME Frieda SLEIN

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 Sam SLEIN 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years abt. 55 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business Housework

12. Name Mendel Slein

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

14. Maiden name Hinda Laha

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

16. (a) Informant Jack Slein

(b) Address 3933 De Touhy

17. (a) Burial (b) Date thereof 3-25-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Cherok Raduska

18. (a) Signature of funeral director Odenhandler

(b) Address 4469 Washington

19. (a) MAR 25 1940 (Date received local registrar) (b) J. Budich (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3933 De Touhy 17 (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 40 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 21 year 1940 hour 4 minute 0 M.

21. I hereby certify that I attended the deceased from Mar 24 1940 to Mar 24 1940

that I last saw her alive on Mar 24 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Green Gall Bladder Colic

Due to: Chronic interstitial nephritis

Due to: None

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations Acute Green Gall Bladder Colic Of autopsy None

Duration

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 Philip Schrak (M. D. or other) Address 17031 Grand Date signed 3/25/40

**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. Penhance*  
.....

..... Licensed Embalmer No. *2669* .....

..... 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.**