. S. No. 2
—11-10-39
v. 5-17-39
1 X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19974
Registrar's No. 4922

Registration District No. 7911 Primary Registration District No. 1003

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: Jewish Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St Louis (If outside city or town limits, write "RURAL") 9
(d) Street No. 1438 E. GRAND (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Fredericka Castleman 234
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 Peise Kestelman
6. (c) Age of husband or wife if alive UNK years
7. Birth date of deceased UNKNOWN (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
AB. 59			hr. min.

9. Birthplace Bucherest (City, town, or county) Roumania (State or foreign country)
10. Usual occupation at home
11. Industry or business
FATHER 12. Name David Bener
FATHER 13. Birthplace (City, town, or county) Roumania (State or foreign country)
MOTHER 14. Maiden name Chaye Greenberg
MOTHER 15. Birthplace (City, town, or county) Roumania (State or foreign country)
16. (a) Informant V. F. Castleman
(b) Address Washington D. C.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 6/5/40 (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) JUN 5 1940 (Date received local registrar) (b) J. B. Budnick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4, 1940 year hour 2 AM minute M.
21. I hereby certify that I attended the deceased from 5/31/40 6/4/40, 19, to, 19; that I last saw him alive on 6/4/40, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage — Duration 5 days
Due to Hypertension
Due to
Other conditions Gen. Arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. M. Kolner (M. D. or other)
Address Jewish Hospital Date signed 6/4/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....1597.....

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.