

No. 2
-13-40
-17-39
X23

FILED SEP 25 1940 791

Primary Registration District No. **1003**

Registrar's No. **6800**

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: Registration - Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community 22 yrs
years, months or days)

3. (a) PRINT FULL NAME BESS R. Deutch 320

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married divorced Married
6. (b) Name of husband or wife Joseph Deutch 6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased Dec 31 1909
(Month) (Day) (Year)

8. AGE: Years 30 Months 7 Days 9 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Housework

12. Name Yonkie Rosen

13. Birthplace Russia 7
(City, town, or county) (State or foreign country)

14. Maiden name Melica Pishemsky

15. Birthplace Russ 7
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Deutch

(b) Address 2918 Forest Drive - Altamont

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation Cherished Smith

18. (a) Signature of funeral director Oxendoller E.P.

(b) Address 4469 Washington Blvd

19. (a) AUG 10 1940 (b) J. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County _____
(c) City or town St. Louis NR
(If outside city or town limits, write "RURAL")
(d) Street No. 2918 Forest Drive Altamont
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 30 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9
year 19 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 3
to Aug 9, 1940
that I last saw her alive on Aug 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Paralytic Illness 2 day
Dilatation of Stomach
Due to Streptococcus
Due to Infection
possibly puerperal
Other conditions non-malignant
(Include pregnancy within 3 months of death)

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

Major findings: Of operations Supra vaginal hysterectomy
Of autopsy no

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 Fred V. Emmerich (M. D. or other) _____
Address 713 Metropolitan Bldg Date signed 8-9-40

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

MOTHER FATHER

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.....

.....
working under my personal supervision.

.....
Registered Apprentice No.....

Signed: *A. B. Greenhand*

Licensed Embalmer No. *3669*

P. O. Address *4464 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26-904
Registrar's No. 6800

Registration District No. _____ Primary Registration District No. _____

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

3. (a) PRINT FULL NAME Bess R. Deratch

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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 7-14-41 (b) J.F. Predeck

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH Month Aug. day 9 - 40
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death acute paralytic
ileus - dilatation
stomach
Due to strep. infection
possibly sepsis
Due to non-malignant
Other conditions 56%
(Include pregnancy within 3 months of death)

Major findings supra vaginal
Of operation hystero-stomy
fibroids of uterus
Of autopsy non-malignant

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

