

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27138

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7034**

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 Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **15 years.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limit, write "RURAL")
(d) Street No. **5899 Bartmer**
(If rural, give location)
(e) If foreign born, how long in U. S. A? **15** years.

3. (a) PRINT FULL NAME **Dora Ehrlich** **1642**

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 **Widow**

6. (b) Name of husband or wife **Barney Noah Ehrlich** 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years Months Days If less than one day
Ab. 77 hr. _____ min.

9. Birthplace **Poldolia** **Russia** 7
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joseph Shayevitch**

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

14. Maiden name **Ethel (unk)**

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

16. (a) Informant **Mrs. Clara Schwartz**

(b) Address **5424 Cabanne**

17. (a) **Burial** (b) Date thereof **8/20/1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chesed Shel Emeth**

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

(b) Address **4716 McPherson**

19. (a) **AUG 20 1940** (b) *J. P. [Signature]*
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **19**
year **1940** hour **7** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **7/26/40**
_____ 19 _____ to **8/19/40** 19 _____;
that I last saw her alive on **8/19/40** 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia** **Eubo.**

Due to **23**

Due to _____

Other conditions **Arterio-sclerotic cords**
(Include pregnancy within 3 months of death) **was under the care**

Major findings: **Pulmonary tuberculosis**
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) (e) Means of injury _____

23. Signature **J. M. Klotner** (M. D. or other)

Address **Jewish Hosp.** Date signed **8/19/40**

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

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

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.....

H. I. BERGER

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

H. I. Berger

Licensed Embalmer No. *1597*

P. O. Address *4715 Mc Pherson*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.