

Registration District No. 784

Primary Registration District No. 20

1. PLACE OF DEATH:

(a) County St. Louis County  
(b) City or town Rural St. Ferdinand  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Frank Sanatorium of St. Louis  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution less 12 days  
(Specify whether)

In this community  
years, months or days

3. (a) PRINT FULL NAME Rebecca Hoven

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.

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive years

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

8. AGE: Years abt 70 Months Days If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business housewife

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Mr. M. Selysoph

(b) Address 1260 7th E. St. St. Louis

17. (a) Burial (b) Date thereof 9-9-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Church of the Holy Trinity

18. (a) Signature of funeral director W. Handley  
(b) Address 4469 Washington

19. (a) SEP - 9 1940 (b) R. M. M. M. M.  
(Date received local registrar) (Registrar's signature)

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. 1438 East Grand Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 40 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 7  
year 1940 hour 12 minute 55 P.M.

21. I hereby certify that I attended the deceased from July 25  
1940 to September 7, 1940

that I last saw her alive on Sept. 7, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to

Due to

Other conditions Reduced fracture of left hip  
(Include pregnancy within 3 months of death)

Major findings: 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?

(e) Means of injury

23. Signature John S. Simpson (M. D. or other)

Address Rural San Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

95B2

**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.

*Not Embalmed*

Signed.....

Licensed Embalmer No.....

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.**

2B  
21-40  
X22659

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 33229

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 1707-

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town .....  
(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 .....  
In this community ..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Rebecca Horan

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 W

6. (b) Name of husband or wife .....

6. (c) Age of husband, or wife, if alive ..... years

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

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

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

10. Usual occupation .....

11. Industry or business .....

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)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

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 Sept. day 7 year 1940 hour ..... minute ..... M.

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

Immediate cause of death Arteriosclerosis of heart & in

Due to ..... Duration 15 1/2 hrs

Due to ..... Reduced fracture of lb. hip -

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: 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) Accident

(b) Date of occurrence About May 1, 1940

(c) Where did injury occur? Jewish Orthodox Old Folks Home, St. Louis, Mo. (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Jewish Orthodox Old Folks Home (Specify type of place) While at work? No. (e) Means of injury Fall

23. Signature [Signature] (M. D. or other) Address [Signature] Date signed .....

SUPPLEMENTARY

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

MOTHER FATHER

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