V. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21492

1909

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. 37503

Registration District No. 7911 Primary Registration District No. 1003 Registrar's No. 9776

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hosp #1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hrs (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St Louis 12 (If outside city or town limits, write "RURAL")

(d) Street No. 724 rear Aubert Ave (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Catherine Lowenstein

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 Widow

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

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

7. Birth date of deceased Abt. (Month) (Day) 1874 (Year)

8. AGE: Years Abt 66 Months Days If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Madge Reeds

(b) Address 724a Aubert.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-29-40 (Month) (Day) (Year)

(c) ~~Place~~: burial or ~~cremation~~ Mt Sinai

18. (a) Signature of funeral director Mayer

(b) Address 4356 Fuselle

19. (a) NOV 28 1940 (Date received local registrar) (b) J. K. Budick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23 year 1940 hour 9 minute 35 A.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.

	Duration
Immediate cause of death Cerebral Apoplexy	
Due to	
Due to	
Other conditions (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 Alfred G. Perry (M. D. or other)

Address Deputy Coroner Date signed 11/28/40

(Licensed Embalmer's Statement on Reverse Side)

Not embalmed

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.....

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.