

MAR 25 1941

Registration District No. 7911

Primary Registration District No. 1003

Registrar's No. 1073

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:
Jewish Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
34 Years (Specify whether years, months or days)
In this community 34 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 96 S
(c) City or town St. Louis (If outside city or town limit write "RURAL") 3 4 3 N, R
(d) Street No. 719 Ireland (If rural, give location) 1
(e) If foreign born, how long in U. S. A.? 34 Years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2
year 1941 hour 12 minute noon M.
21. I hereby certify that I attended the deceased from 1/20/41
2/2/41, 1941, to 2/2/41, 1941;
that I last saw him alive on 2/2/41, 1941;
and that death occurred on the date and hour stated above.
Immediate cause of death uremia

Duration
wks?

Due to arteriosclerotic heart dis;
cardiac decompensation
hypertension
Due to Diabetes mellitus
Other conditions (Include pregnancy within 3 months of death) 77

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

Major findings:
Of operations. 77
Of autopsy. 77

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 0
23. Signature L M Kotler (M. D. or other)
Address Jewish Hosp Date signed 2/2/41

8. (a) PRINT FULL NAME Lena Levitt or Leavitt

8. (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 Widowed
6. (b) Name of husband or wife Max Levitt 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
Abt. 60 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Housework

MOTHER FATHER { 12. Name Avrom Itzhock Shafkowitz
13. Birthplace Russia
(City, town, or county) (State or foreign country)
14. Maiden name Gittle
15. Birthplace Russia
(City, town, or county) (State or foreign country)

16. (a) Informant George Leavitt
(b) Address 5808 Meffit

17. (a) Burial (b) Date thereof 2 3 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beth Hamodrosh Hagodol

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

19. (a) FEB 3 1941 (b) JTBrecher
(Date received local registrar) (Registrar's signature)

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

1940

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.....

myself
.....
working under my personal supervision.

Registered Apprentice No.....

Signed *W. J. O'Connell*
.....
Licensed Embalmer No. *3669*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4825-

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 1073

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
years, months or days)

3. (a) PRINT FULL NAME Lena Levitt or Leath

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 wid

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: wht 60 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-14-41 (b) J. J. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis
(c) City or town University
(If outside city or town limits, write "RURAL") D. R.
(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2
year 1941 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 _____

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 sta-
tistically.

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)
Means of injury _____

23. Signature Em Rotner (M. D. or other)

Address General Hospital Date signed _____

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

SUPPLEMENTAL

