

No. 2
1-10-39
-17-39
X21492

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19027

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 985

1. PLACE OF DEATH: St. Louis, Paternal
 (a) County: St. Louis
 (b) City or town: Royal, St. Ferdinand
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Jeunin Sanatorium of St. Louis
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 1 year 5 mo. 30 d.
 (Specify whether In this community: 2 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
 (a) State: Mo. Howi (b) County: 17
 (c) City or town: St. Louis 9
 (If outside city or town limits, write "RURAL")
 (d) Street No.: 1363 a Belt Avenue 1
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.: 29 years.

3. (a) PRINT FULL NAME: Tillie Fine
 3. (b) If veteran, name war: -
 3. (c) Social Security No.: -

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 8
 year 1941 hour 11 minute 30 p. M.

4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced: married
 6. (b) Name of husband or wife: Louis Fine 6. (c) Age of husband or wife if alive: 65 years
 7. Birth date of deceased: unknown (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 12, 1939, to May 8, 1941;
 that I last saw her alive on May 8, 1941;
 and that death occurred on the date and hour stated above.

8. AGE: Years about 57 Months Days If less than one day hr. min.

Immediate cause of death: Conyestive heart failure, anemia
 Due to: Rheumatic heart disease
 Due to: _____
 Other conditions (Include pregnancy within 3 months of death): _____

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)
 10. Usual occupation: Home work
 11. Industry or business: Housewife
 12. Name: Berwinia Handloff
 13. Birthplace: _____ (City, town, or county) _____ (State or foreign country)
 14. Maiden name: Parisi
 15. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

16. (a) Informant: Louis Fine
 (b) Address: 1363 a Belt av
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 9-41 (Month) (Day) (Year)
 (c) Place: burial or cremation: Chievel Kadoka
 18. (a) Signature of funeral director: Hubert L. ...
 (b) Address: 4467 ...
 19. (a) MAY 9 - 1941 (Date received local registrar) (b) [Signature] (Registrar's signature)

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: [Signature] (M. D. or other) (1)
 Address: Jeunin Sanator. Date signed: 5-9-41

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

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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

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

working under my personal supervision.

Signed

W. J. Chenhault

Licensed Embalmer No. *3669*

P. O. Address.....

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.

4-25-41
X27852

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19D 27
Registrar's No. 985

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH
(a) County St. Louis
(b) City or town _____
(c) Name of hospital or institution: Jerome Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Lillie Lure
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 M

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 57 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 _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

19. (a) 5-9-41 (b) T. P. [Signature]
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month May day 8 - 1941
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Congestive heart failure
Due to Necrosis - (Congestive Heart Failure) 141110
Pneumatic heart disease
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature John [Signature] (M. D. or other) _____
Address Jerome Hospital Date signed _____

SUPPLEMENTARY

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

S-19027 1941