

FILED NOV 24 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33203  
8158

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

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:  
4440 So. 37th Street  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 009  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 4440 So. 37th St. (If rural, give location)  
Am Citizen  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12  
year 1941 hour 11 minute 0 M.  
21. I hereby certify that I attended the deceased from June 10  
1941 to Oct. 12, 1941  
that I last saw her alive on Oct. 12, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death: Metastatic carcinoma of endometrium  
Duration 3 yrs.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) MD  
Address 7542 S. Grand Date signed 10/13/41

3. (a) PRINT FULL NAME Sophie Jacobson  
(b) If veteran, name war no (c) Social Security No. no

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
(b) Name of husband or wife Joseph Jacobson 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Nov. 7, 1883  
(Month) (Day) (Year)

8. AGE: Years 57 Months 11 Days 5  
If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Morris Grinetz  
13. Birthplace Roumania  
(City, town, or county) (State or foreign country)  
14. Maiden name Rachel (unk)  
15. Birthplace Roumania  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Harold Cohen  
(b) Address 4440 So. 37th St.  
17. (a) burial (b) Date thereof 10/15/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

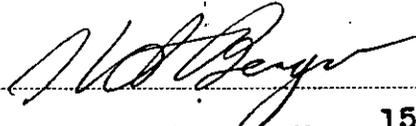
(c) Place: burial or cremation Bnai Amoona Berger Memorial  
18. (a) Signature of funeral director 4715 McPherson  
(b) Address  
19. (a) OCT 14 1941 (b) J. F. Bradeck  
(Date received local registration) (Registrar's signature)

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed



Licensed Embalmer No. **1597**

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, fact should be so stated above.**