

S. No. 2
—1-4-41
5-17-39
PI X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33535**

Registrar's No. **8493**

FILLED NOV 21 1941
Registration District No. **791**

Primary Registration District No. **1003**

00
17
9
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:
5517 Pershing
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5517 Pershing**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Clara Stein**

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 2**
6. (b) Name of husband or wife **Julius Stein** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct. 18 1852**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 --- **9** hr. min.

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

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Max Stein**
(b) Address **5517 Pershing**

17. (a) **Burial** (b) Date thereof **10-27-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Sinai Cemetary**

18. (a) Signature of funeral director **A. Rindorf**
(b) Address **5216 Delmar Blvd.**

19. (a) **OCT 27 1941** (b) **J. J. Brudek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **25**
year **1941** hour _____ minute **10** A. M.

21. I hereby certify that I attended the deceased from **10/20/40**
19 _____ to **10/27/41** 19 _____
that I last saw her alive on **10/25** 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death **Carbonic of liver** Duration **1 yr**

Due to _____
Due to **1st H**
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 **J. J. Brudek** (M. D. or other) _____
Address **1259 N. Kingshighway** Date signed **10/27/41**

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.....

C. W. Cooper

Licensed Embalmer No. *3830*

P. O. Address.....

5216 Belmar

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.