

FILED FEB 16 1943
Registration District No. **1008**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **three weeks**
(Specify whether
In this community **about 25 years**
years, months or days)

3. (a) PRINT FULL NAME **Anna G. Manne**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **486-28-2991**

4. Sex **female** / 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Joseph Manne** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **March 18 1897**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
45 10 15 hr. min.

9. Birthplace **Paducah Ky. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Meyer Gladstein**
13. Birthplace **Poland 4**
(City, town, or county) (State or foreign country)
14. Maiden name **Faye Levinsky**
15. Birthplace **Poland 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lee Gladstein**

(b) Address **Scottsburg Ind.**

17. (a) **Burial** (b) Date thereof **2-3-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Mayer**

(b) Address **4356 Lindell Blvd**

19. (a) **FEB 3 1943** **J. F. Bruleak**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **1800**
(If outside city or town limits, write "RURAL") **19**
(d) Street No. **4605 Lindell Blvd** **9**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **2**
year **1943** hour **1** minute **a** M.

21. I hereby certify that I attended the deceased from **Jan**
_____, 19 **42** to _____, 19 _____;
that I last saw h. e. alive on **2/1**, 19 **43**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of breast with metastasis to lung.**

Due to _____
Due to **50**
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **Removal of breast**
Of operations **March 1942.**
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:

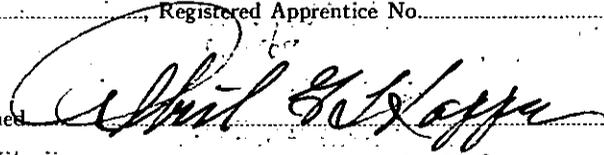
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature **A. Goldman** (M. D. or other) **md**
Address **634 N. Grand** Date signed **2/3/43**

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. 2971.....
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.