

FILED APR 19 1943
Registration District No. 518

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(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 SARAH KLAVIN

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 Married

6. (b) Name of husband or wife Albert Klaven 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 42 -- -- hr. min.

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

10. Usual occupation at home

11. Industry or business.....

12. Name Abram Stein

13. Birthplace Austria
(City, town, or county) (State or foreign country)

14. Maiden name Bessie Gordon
(City, town, or county) (State or foreign country)

15. Birthplace Austria
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Klaven

(b) Address 5769 Kingsbury

17. (a) Burial (b) Date thereof 4-4-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation B'NAI Amoona Cem.

18. (a) Signature of funeral director [Signature]

(b) Address 5216 Delmar Blvd

19. (a) 9 1943 (b) J. F. Bruck
(Date received local registrar) (Registrar's signature)

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. 5769 Kingsbury
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 2
year 1943 hour 3:40 minute A M.

21. I hereby certify that I attended the deceased from MARCH 10, 1943, to APR. 2, 1943;
that I last saw her alive on APRIL 2, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Abscess Duration 10 d.
came not turn

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death).....

Major findings: Of operations Brain Abscess

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 M. C. Abney (M. D. or other)

Address BARNES HOSPITAL Date signed 4/2/43

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..... *C. W. Cooper*

Licensed Embalmer No. *3830*

P. O. Address. *5216 Delmar*

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.