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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 4 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16138

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4749

19

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:
Isolation Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 Hours (Specify whether
In this community 37 yrs
years, months or days)

3. (a) PRINT FULL NAME Rose Gralnick, also known as Rachel Gralnick,

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife David Gralnick

6. (c) Age of husband or wife if alive (unk) years

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

8. AGE: Years ab. 62 | Months | Days | If less than one day hr. min.

9. Birthplace Volhynia (City, town, or county) Russia 6 (State or foreign country)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Hyman Ussen
13. Birthplace (City, town, or county) Russia 6 (State or foreign country)

MOTHER
14. Maiden name Bessie (unk)
15. Birthplace (City, town, or county) Russia 6 (State or foreign country)

16. (a) Informant Henrietta Buchanan
(b) Address Isolation Hospital

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 5/23/43 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 McPherson

19. (a) MAY 23 1943 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000 12 9 6

(a) State Mo. (b) County

(c) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 5447 A Easton
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country Alien # 1668266 en 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21
year 1943 hour 8 minute A M.

21. I hereby certify that I attended the deceased from May 20, 1943, to May 21, 1943;
that I last saw her alive on May 21, 1943;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Meningococcus Meningitis	24 hrs
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature David Goldberg (M. D. or other) 0
Address St. Louis Isolation Date signed 5-21-43

(Licensed Embalmer's Statement on Reverse Side)

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.