

Registration District No. **100318**

Primary, Registration District No. **1003**

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:  
Jewish Hospital 0  
(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 **2300**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1920 S. Broadway **17**  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0 **7**

3. (a) PRINT FULL NAME Rose Goldwasser Zarkoff

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 2 divorced  
6. (b) Name of husband or wife Morris Zarkoff 6. (c) Age of husband or wife if alive (unk) years  
7. Birth date of deceased April 1885  
(Month) (Day) (Year)

8. AGE: Years 58 Months 2 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation at home

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

MOTHER FATHER { 12. Name Hyman Israel Zweig  
13. Birthplace Austria  
(City, town, or county) (State or foreign country)  
14. Maiden name Felche Schwartz  
15. Birthplace Austria  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Isabelle Brasch  
(b) Address 5333 Maple Ave.

17. (a) burial (b) Date thereof 6/11/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Chesed Shel Emet

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

19. (a) JUN 11 1943 J. J. Bralock  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8  
year 1943 hour 3 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from May 28 1943  
to June 8 1943  
that I last saw her alive on June 8 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death degenerative heart disease  
Due to Diabetes mellitus  
Due to Chronic nephritis  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 Albert B. Tausing (M. D. or other) M.D.  
Address 4500 Olive St. St. Louis Mo. Date signed 6/9/43

Duration ?  
?  
?  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

844

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

000  
17  
9

---

---

**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.....

St. Louis, Mo.

**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.**