

FILED NOV 10 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9582**

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: JACOBISH HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 DAYS  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 96

(c) City or town UNIVERSITY CITY  
(If outside city or town limits, write "RURAL")

(d) Street No. 710 SYRACUSE  
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Powers

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 30  
year 1943 hour 9 minute a. M.

21. I hereby certify that I attended the deceased from 10/1, 1943 to 10/30, 1943  
that I last saw him alive on 10/29/43, 1943  
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Earl Powers

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

7. Birth date of deceased Sept. 22 1879  
(Month) (Day) (Year)

Immediate cause of death Hemiplegia left (Cerebral thrombosis)

Due to	Duration
<u>art. sclerosis</u>	<u>12 mos</u>
_____	_____
_____	_____

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>1</u>	<u>8</u>	_____ hr. _____ min.

Other conditions (include pregnancy within 3 months of death) 83

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace RUSSIA G  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWORK

11. Industry or business HOUSEWIFE

12. Name ISRAEL SCHOCKMAN

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

14. Maiden name RUSHEL

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

16. (a) Informant Rose Rodenberg

(b) Address 826 Ireland

17. (a) BURIAL (b) Date thereof 11-2-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation B'NAY AMOON

18. (a) Signature of funeral director Odenhandler

(b) Address 4469 WASHINGTON

19. (a) NOV 1 (b) 1943  
(Date received local registrar) (Registrar's signature)

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 Arthur E. Stead (M. D. or other) \_\_\_\_\_

Address 532 N. 9th Date signed 10/30/43

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

MOTHER FATHER

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**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 *W. J. Keschandler*.....  
Licensed Embalmer No. *3669*.....

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.**