

FILED JAN 3 1944

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 295-1

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1712a Yale Ave
(If not in hospital or institution, write street number or location)

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

In this community 35 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Fannie Stein

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, widowed 2 divorced widowed

6. (b) Name of husband or wife Max Stein

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

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

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

MOTHER FATHER {

12. Name David Zaichik

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

14. Maiden name (unk)

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

16. (a) Informant David Stein

(b) Address 1712a Yale

17. (a) burial (b) Date thereof 12/28/43
(Burial, cremation, or removal) (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) DEC 29 1943 (b) E. J. McPherson, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")

(d) Street No. 1712a Yale
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26
 year 1943 hour 10:30 minute P M.

21. I hereby certify that I attended the deceased from Nov. 22
1943, to Dec. 26 1943
 that I last saw her alive on Dec. 26 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Myocardial infarction</u>	<u>1 hour</u>
Due to <u>Coronary occlusion</u> <u>Arteriosclerotic heart disease</u>	<u>1 hour</u> <u>6 mo.?</u>
Due to _____	_____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations 930

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)

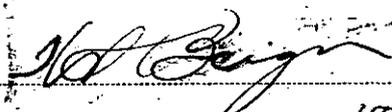
While at work? _____ (e) Means of injury _____

23. Signature Barrett L. Tansig (M: D. or other) M.D.
 Address 4500 Olive St Date signed Dec 27

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.....

1097

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.