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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8983
Registrar's No. 3086

Registration District No. 318

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
(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 96
(c) City or town Clayton (If outside city or town limits, write "RURAL") 2
(d) Street No. # 7 Crestwood Dr. (If rural, give location) 3 NR.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Pauline S. Goldman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Louis Goldman 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 24 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Nathan Silver

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

14. Maiden name Sara Lipfeld

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

16. (a) Informant Samuel B. Edison

(b) Address #7 Crestwood Dr.

17. (a) Burial (b) Date thereof 4-2-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cemetery

18. (a) Signature of funeral director Herman Rindberg

(b) Address 5216 Delmar Blvd.

19. (a) APR 2 1944 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
year 1944 hour 4 minute 9 M.

21. I hereby certify that I attended the deceased from June 31, 1944 to March 31, 1944
that I last saw him alive on March 31, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary thrombosis 4 days

Due to Chs Hypertension 8 yrs

Due to Arteriosclerosis 8 yrs

Other conditions _____
(Include pregnancy within 3 months of death) 61

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

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 G. M. Grant (M. D. or other) MD

Address 3651 Grand Ave Date signed 4/1/44

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

MOTHER FATHER

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.....

John Ketter

Licensed Embalmer No. 3830

P. O. Address. 4355 Washington

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.