

FILED MAY 9 1944

State File No. _____

Registration District No. **818**

Primary Registration District No. **1003**

Registrar's No. **3932**

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 _____
(c) City or town **Robertson**
(If outside city or town limits, write "RURAL")
(d) Street No. **Fee Fee Sanatorium**
(If rural, give location) **N.R.**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Sarah Friedman**

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 **Samuel P. Friedman** 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years **about 62** Months **--** Days **--** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Paul Goldblum**

(b) Address **225 S. Skinner**

17. (a) Burial (b) Date thereof **4-28-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Herman Rindskopf**

(b) Address **5216 Delmar Blvd.**

19. (a) **APR 27 1944** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **27**
year **1944** hour **4:30** minute **9** M.

21. I hereby certify that I attended the deceased from **4-22**, 19**44**, to **4-27**, 19**44**,
that I last saw him alive on **4-26**, 19**44**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Peritonitis**

Due to **Undetermined origin**

Due to **Hypertension**

Other conditions **Removal of Cerebral Hemorrhage**
(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)

(c) Means of injury _____

23. Signature **J. F. Brudeck** (M. D. or other) _____
Address **Jewish Hosp.** Date signed **7/27/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 5216 Delmar

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.