

FILED SEP 18 1944  
Registration District No. 1944 8

Primary Registration District No. \_\_\_\_\_

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_  
 (c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1439 ROWAN  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Anna Gordon (ANNIE)

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Late SAM GORDON 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

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

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

10. Usual occupation House wife

11. Industry or business HOUSE WORK

MOTHER FATHER { 12. Name JOSEPH KRAMER  
 13. Birthplace RUSSIA  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name CHIA REZI  
 15. Birthplace RUSSIA  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. James Lane  
 (b) Address 1439 ROWAN

17. (a) BURIAL (b) Date thereof 9-5-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel EMETH  
Memorials

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address 4469 WASHINGTON

19. (a) SEP 5 1944 (b) J. Medel  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 4  
 year 1944 hour 10 minute 26 A.M.

21. I hereby certify that I attended the deceased from 9/1  
 \_\_\_\_\_, 1944 to 9/4, 1944  
 that I last saw her alive on 9/4, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 days

Due to arteriosclerosis ?  
hypertension ?

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature David Friedman (M. D. or other) MD  
 Address Jewish Hosp Date signed 9/4/44

**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.....

working under my personal supervision.

Registered Apprentice No.....

Signed

*W. B. Renhander*

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.**