

S. No. 2  
1-8-43  
5-17-39  
P 1 X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29814

State File No.

FILED SEP 18 1944

1003

Registration District No. 318

Primary Registration District No.

Registrar's No. 7725

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 \_\_\_\_\_ (Specify whether)

In this community 55 years 0  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 66 Broadview  
(If rural, give location)

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

3. (a) PRINT FULL NAME Annie Srenco

3. (b) If veteran, name war no

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6<sup>th</sup> day Sept.  
year 1944 hour 9 minute 10A M.

21. I hereby certify that I attended the deceased from Aug 31  
1944 to Sept 6 1944.

that I last saw her alive on Sept 6 1944  
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 Widow

6. (b) Name of husband or wife Isadore Srenco

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

7. Birth date of deceased Oct. 17, 1872  
(Month) (Day) (Year)

Immediate cause of death

Cardiac decompensation acute  
Arteriosclerotic heart disease  
Due to emphysema of gall bladder

Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day

71 10 19 hr. \_\_\_\_\_ min.

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

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

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

Of autopsy NONE

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9. Birthplace Kiev USSR. 6  
(City, town, or county) (State or foreign country)

10. Usual occupation retail shoe merchant

11. Industry or business retired

MOTHER FATHER { 12. Name Jacob Feldman

13. Birthplace USSR. 6  
(City, town, or county) (State or foreign country)

14. Maiden name Sophie Sherman

15. Birthplace USSR. 6  
(City, town, or county) (State or foreign country)

16. (a) Informant Oscar Srenco

(b) Address 250 S. Brentwood

17. (a) Burial (b) Date thereof 9/7/1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth Berger Memorial

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 4715 Mc. Pherson

19. (a) SEP 7 1944 (b) \_\_\_\_\_  
(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? \_\_\_\_\_

(Specify type of place)

While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Herminia M. Meyer (M. D. or other) MD  
Address 508 N. Grand Date signed 9/6/44

(Licensed Embalmer's Statement on Reverse Side)

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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.....

Licensed Embalmer No. *1597*.....

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.**