

1. PLACE OF DEATH:
(a) County St. Louis Robertson
(b) City or town St. Ferdinand Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: JEWISH SANATORIUM
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 years
(Specify whether years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Rural Robertson 0
(If outside city or town limits, write "RURAL")
(d) Street No. Jewish Sanatorium
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME SARA MARCUS
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 widow
6. (b) Name of husband or wife Israel Marcus
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
ab. 64 hr. min.

9. Birthplace: USSR. 12
(City, town, or county) (State or foreign country)

10. Usual occupation: at home

11. Industry or business:

MOTHER FATHER { 12. Name: Abraham Petuch 1
13. Birthplace: USSR. 6
(City, town, or county) (State or foreign country)
14. Maiden name: Esther Arloff
15. Birthplace: USSR. 12
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Anna Dressler
(b) Address: 5837 Nina Pl.

17. (a) Burial (b) Date thereof: 9/29/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Bnai Ammona
18. (a) Signature of funeral director: Berger Memorial
(b) Address: 4715 Mc Pherson

19. (a) SEP 29 1944 (b) E. S. McPherson M.D.
(Date registered) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 26
year 1944 hour 7 minute 50 P.M.
21. I hereby certify that I attended the deceased from Dec. 7-1937
1937 to Sept. 26 1944
that I last saw her alive on Sept. 26, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Arterio-sclerotic Heart disease
Duration: 7 years

Due to: _____
Due to: _____

Other conditions: none
(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none 9/26

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: 0

23. Signature: [Signature] (M. D. or other)
Address: JEWISH SANATORIUM Date signed: 9/26/44

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

600

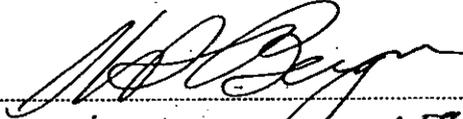
OCT 27 1944

OCT 17 1944

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.