

FILED DEC 15 1944

Primary Registration District No. _____

Registrar's No. **10466**

1. PLACE OF DEATH
(a) County St. Louis
(b) City or town _____
(c) Name of hospital or institution: General Hosp
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 23 years years, months or days)

3. (a) PRINT FULL NAME SARAH LEVIN
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 Widowed
6. (b) Name of husband or wife, Sarah Levin 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
<u>abt. 69</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>min.</u>

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

10. Usual occupation housework

11. Industry or business home

12. Name Mayer

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

14. Maiden name Chira

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

16. (a) Informant Wanuel Levin

(b) Address 6641 San Bonito

17. (a) Burial (b) Date thereof 12/10/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cherish Kadishy

18. (a) Signature of funeral director W. G. Pennington

(b) Address 1449 W. Washington Blvd

19. (a) DEC 8 (b) J. F. Bechtel
(Date received local registrar) (Registrar's signature)

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. 1296 1/2 Madonna Ave
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country Austria & Russia

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 7th
year 1944 hour 5 minute _____ P. M.

21. I hereby certify that I attended the deceased from 12/6/44
_____, 19____, to 12/7/44, 19____;
that I last saw her alive on 12/7/44, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute pharyngitis
Duration 4 days

Due to _____
Due to 1/5

Other conditions _____
(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)
(e) Means of injury _____

23. Signature Maxwell Finberg (M. D. or other)
Address 607 N. Grand Ave. Date signed 12/8/44

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.....

myself
....., Registered Apprentice No.
working under my personal supervision.

Signed.....

W. G. Jenks

.....
Licensed Embalmer No. *3669*

P. O. Address. *4469 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.