

S. No. 2
M-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 22 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36354

FILED NOV 22 1944
Registration District No. 318

Primary Registration District No. 1000

State File No. 36354
Registrar's No. 9556

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 20 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 17
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 953 Beach
(If rural, give location)
(e) Citizen of foreign country? Alien (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Zippa Rubinowitz, also known as
CELA RUBIN VOIN

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 13
year 1944 hour 10 minute 30 p M.

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

21. I hereby certify that I attended the deceased from Oct 6
11 1943 to Nov. 13 1944
that I last saw h. er alive on _____ " _____ 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 Henry Rubin 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased (unk.)
(Month) (Day) (Year)

Immediate cause of death Carcinoma of both ovaries -
Duration 15 mo

8. AGE: Years 71 Months _____ Days _____ If less than one day
hr. _____ min. _____

Due to _____
Due to _____
Other conditions H-9
(Include pregnancy within 3 months of death)

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

Major findings: _____
Of operations _____
Of autopsy none
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation at home

11. Industry or business _____

12. Name Benjamin Melayeff

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

14. Maiden name Etta (unk.)

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

16. (a) Informant Jacob Rubin
(b) Address 953 Beach

17. (a) Burial (b) Date thereof 11/14/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Beth Ham. Hag.

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? _____

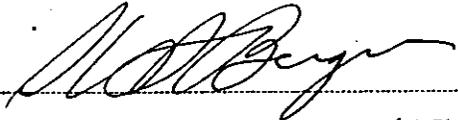
18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 Mc. Pherson
19. (a) NOV 14 1944 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature W. K. Taylor (M. D. or other)
Address 462 N. Taylor Date signed 11/13/44

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.....
....., 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.