

No. 2  
-2.43  
5-17-39  
X2697

**FILED DEC 7 1944**  
Registration District No. **377**

Primary Registration District No. **3063**

Registrar's No. **2114**

**1. PLACE OF DEATH:**

(a) County St. Louis

(b) City or town Clayton Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
7246 Wydown  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
Life (Specify whether)

In this community \_\_\_\_\_  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County 00

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 220 N. Kingshighway  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** Florence Bauman Sternberg

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct. day 13  
year 1944 hour 9:58 minute A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Open verdict. Duration \_\_\_\_\_

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

6. (b) Name of husband or wife Jerome Sternberg 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 29, 1894  
(Month) (Day) (Year)

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

<u>53</u>	<u>1</u>	<u>20</u>	hr. _____ min. _____
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9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

12. Name Samuel Bauman

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

14. Maiden name Hannah Loewenstein

15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Leo Bauman

(b) Address 738 S. Hanley

17. (a) Burial (b) Date thereof 10/15/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer

(b) Address 4356 Lindell Blvd

19. (a) OCT 17 1944 (b) E. J. Mollan  
(Date received local registrar) (Registrar's signature)

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

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

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

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

Of autopsy Yes.

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

**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 3

23. Signature E. J. Mollan Deputy Registrar

(Date received local registrar) (Registrar's signature) Address: Clayton, Mo Date signed 10-14-44

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

OCT 23 1946

**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.....

*John Agonochi*

Licensed Embalmer No. *3398*

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.**

Registration District No. 311 Primary Registration District No. 3063

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

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

3. (a) PRINT FULL NAME Florence B. Sternberg  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 29 (Month) (Day) (Year)

8. AGE: Years 53 Months 1 Days 16 If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER } 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day \_\_\_\_\_ year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

**SUPPLEMENTARY**  
CHLORAL HYDRATE POISONING  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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) SUICIDE  
(b) Date of occurrence October 13, 1944  
(c) Where did injury occur? Clayton St. Louis Mo. (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home  
While at work? No (Specify type of place) (e) Means of injury Liquid poison  
23. Signature H. S. Chesapeake M.D. or other M.D.  
Address 601 Brentwood, Clayton Date signed 12/11/44

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