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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 16 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

776

State File No. _____

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 146

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 1 week (Specify whether years, months or days)
In this community 19 YEARS

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. 1330 CLARA
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country N

3. (a) PRINT FULL NAME SARAH SHTROM
3. (b) If veteran, name war _____
3. (c) Social Security No. _____
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased UNKNOWN (Month) (Day) (Year)
8. AGE: Years 37 Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace RUSSIA (City, town, or county) (State or foreign country)
10. Usual occupation FINISHER
11. Industry or business DRESS
MOTHER FATHER
12. Name AARON SHTROM
13. Birthplace RUSSIA (City, town, or county) (State or foreign country)
14. Maiden name BESSIE BAER
15. Birthplace RUSSIA (City, town, or county) (State or foreign country)
16. (a) Informant Moris Shtrom
(b) Address 395 Shawnee
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel EMETH
18. (a) Signature of funeral director Orenhandler
(b) Address 4469 Washington
19. (a) JAN 8 1945 (Date received local registrar) (b) J. F. Breden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6 year 1945 hour 3 minute 30 P.M.
21. I hereby certify that I attended the deceased from Dec 30, 1944, to Jan 6, 1945, that I last saw her alive on Jan 6, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Anuria	7 days
Due to: Postoperative cause undeterminable	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Fibroid of uterus non-malignant	
Of autopsy:	

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 _____
23. Signature Charles H. Kopp (M. D. or other) M.D.
Address 4500 Olive Date signed 1/6/45

(Licensed Embalmer's Statement on Reverse Side)

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 H. Z. Ofenhandler

Licensed Embalmer No. 3669

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.