S. No. 2
0M—2-43
v. 5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3556

FILED FEB 13 1945

Registration District No. 317

Primary Registration District No. 2002

Registrar's No. 2961

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis - U. City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home--6709 Chamberlain
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 35 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis

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

(d) Street No. 6709 Chamberlain
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME BESSIE PORTNOY

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Late Harry Portnoy

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years Abt. 68 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Housework

FATHER
12. Name Joseph Kidder,
13. Birthplace (City, town, or county) Russia (State or foreign country)

MOTHER
14. Maiden name Leah
15. Birthplace (City, town, or county) Russia (State or foreign country)

16. (a) Informant Dave Portnoy
(b) Address 9 Craybridge Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Oxenhandler
(b) Address 4469 Washington

19. (a) ~~JAN 30 1945~~ (Date received for Registrar) (b) E. G. McGavran M.D. (Registrar's signature) Cmpo

2/3/45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 27 day Jan year 1945 hour 4 minute 10 a. M.

21. I hereby certify that I attended the deceased from Jan 15, 1945, to Jan. 27, 1945 that I last saw her alive on Jan 27, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho-pneumonia	12 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 107	

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? (Specify type of place)

While at work? (e) Means of injury

(f) Signature Jos. P. Berman (M. D. or other)

Address 1225 - No. Grand Date signed 1/27/45

(Licensed Embalmer's Statement on Reverse Side)

FEB 26 1945

FEB 16 1945

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. B. Reinhardt

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.