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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4221

State File No.

1867

FILED MAR 3 1945

Registration District No. 318

Primary Registration District No. 1005

Registrar's No.

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:
5716 Westminster Avenue
(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 CELIA FISHGALL

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 Married

6. (b) Name of husband or wife Harry Fishgall 6. (c) Age of husband or wife if alive 75 years

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

8. AGE: 23 Years Months Days If less than one day
About hr. min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Dr. Edward Fishgall

(b) Address 5716 Westminster

17. (a) Burial (b) Date thereof 2-25-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth Cem.

18. (a) Signature of funeral director H. R. ...
(b) Address 5216 Delmar Blvd.

19. (a) FEB 26 1945 (b) J. F. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5716 Westminster
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February, day 24
year 1945 hour 8 minute 20 M.

21. I hereby certify that I attended the deceased from Oct 9, 1939
Oct 9, 1939, to _____, 19____
that I last saw her _____ alive on 1-8-, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary infarction
Duration _____

Due to arteriosclerotic Heart Disease
Hypertension angina pectoris 6-7 yrs.
Due to Diabetes mellitus 14 yrs.

Other conditions _____
(Include pregnancy within 3 months of death) 61.

Major findings:
Of operations _____
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:

(c) 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 _____

23. Signature: Harold K. Robert (M: D: or other) _____
Address 7720 Washburn Date signed 2-26-45

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

Signed H. P. Burgess
Licensed Embalmer No. 4029
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.