

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PEN.

FILED FEB 28 1945

1003

1. PLACE OF DEATH:
(a) County St. Louis
(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 55 years 0 (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Anna Levinson
3. (b) If veteran, name war no 3. (c) Social Security No. no
4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widow
6. (b) Name of husband or wife Harry Levinson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 21, 1878
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 8
year 1945 hour 5 minute 15 A. M.
21. I hereby certify that I attended the deceased from Feb. 7, 1945 to Feb 8, 1945
that I last saw her alive on Feb 7, 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Acute coronary
occlusion. Duration 36 hrs

8. AGE: Years Months Days If less than one day
66 2 17 hr. _____ min.

Due to General arterio-sclerosis
arterial hypertension
Due to _____

9. Birthplace Belorodka Volhybia Poland 4
(City, town, or county) (State or foreign country)

Other conditions Diabetes Mellitus 15 yrs +
(Include pregnancy within 3 months of death)
Hemiplegia 2 years

10. Usual occupation at home

PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business Jacob Goldberg

MOTHER FATHER { 12. Name Jacob Goldberg
13. Birthplace Poland 4
(City, town, or county) (State or foreign country)

14. Maiden name Bessie Rachel (unk)
(City, town, or county) (State or foreign country)

15. Birthplace Poland 4
(City, town, or county) (State or foreign country)

16. (a) Informant I. Niss
(b) Address 700 Leland U. City

17. (a) burial (b) Date thereof 2/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director 4715 McPherson ave.
(b) Address

19. (a) FEB 11 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____
Of autopsy none

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?

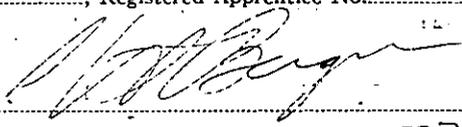
While at work? _____ (Specify type of place)
(a) Means of injury 0
23. Signature Verone O Cook (M. D. or other)
Address 508 N. Grand Date signed 2/8/45

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.