

S. No. 2
M-5-43
7-5-17-39
I X36671

FILED APR 23 1945
Registration District No. 3145

Primary Registration District No. 1003

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

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 OLD FOLKS HOME
(If not in hospital or institution, write street number or location)
1438 E. GRAND BLVD
(d) Length of stay: In hospital or institution 2 YEARS
(Specify whether
In this community 25 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000
(c) City or town ST. LOUIS 119
(If outside city or town limits, write "RURAL")
(d) Street No. 1438 E. GRAND BLVD
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROSE SHAFER

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 WIDOWED
6. (b) Name of husband or wife LATE SIMON SHAFER 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>Adt.</u>	<u>73</u>			hr. _____ min.

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

10. Usual occupation HOUSEWORK

11. Industry or business HOUSEWIFE

12. Name USHER FRIEDMAN

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

14. Maiden name LARA

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

16. (a) Informant Mrs Beanie Shaper

(b) Address 450 N. 26th St. East St. Louis

17. (a) BURIAL (b) Date thereof 4-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CHESED SHELEMETH

18. (a) Signature of funeral director Odenhoffer

(b) Address 4469 Washington Blvd.

19. (a) APR 11 1945 (b) J. J. Bradeau
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1945 - hour 11 minute 00 P. M.

21. I hereby certify that I attended the deceased from Feb 15
_____, 1945 to April 10, 1945
that I last saw h. or alive on April 10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumo pneumonia Duration 2 days

Due to 107

Due to _____
Other conditions Parkinson's Disease years
(Include pregnancy within 3 months of death) Not result of

Major findings: encephalitis **PHYSICIAN**
Of operations: _____
Underline the cause to which death should be charged statistically.

Of autopsy _____

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 0

23. Signature Frank Cohen (M. D. 0)
Address 462 N. Taylor Date signed 4/11/45

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

W. B. Overhauled

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.