

Registration District No. **317**

Primary Registration District No. **6076**

**1. PLACE OF DEATH:**

(a) County **St. Louis**  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution  
**Edgewood Retreat**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 days**  
In this community **10 days**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Stella Meyer Lerner**

3. (b) If veteran, name war **no**  
3. (c) Social Security No. **no**

4. Sex **male**  
5. Color or race **white**  
6. (a) Single, widowed, married, divorced **Widower**

6. (b) Name of husband or wife **Pauline Carmen Lerner**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Sept. 24, 1875**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**69 6 7** hr. min.

9. Birthplace **Kiev U.S.S.R.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **haberdasher**

11. Industry or business **retired**

12. Name **Simon Lerner**

13. Birthplace **U.S.S.R.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Jennie Zuckerman**

15. Birthplace **U.S.S.R.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Dorothy Katleman**

(b) Address **7716 Stanford U. City**

17. (a) **burial** (b) Date thereof **4/3/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chesed Shel Emeth**

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

19. (a) **APR 4 1945** (b) **E. B. M. Pearson, M.D.**  
(Date received local health officer) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **49**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **201 W. 54 st.**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **4** day **1**  
year **1945** hour **6** minute **10** P. M.

21. I hereby certify that I attended the deceased from **3/29**  
**1945** to **4/1 1945**  
that I last saw h. **im** alive on **3/29**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**  
Duration **10 minutes**

Due to **Generalized Arterio-Sclerosis** **YRS**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **none** **94a**

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 **John W. King, M.D.** (M. D. or other)  
Address **678 Big Bend Rd. Joplin, Mo.** Date signed **4/1/45**

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

**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.**