

JUN 30 1945
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5229**

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:
Missouri Baptist Hospital (1)
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **000**
17

(c) City or town: **St. Louis** **6 6**
(If outside city or town limits, write "RURAL")

(d) Street No.: **1368 Arlington**
(If rural, give location)

(e) Citizen of foreign country?..... (1) (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **JEANETTE ISAACSON**

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: **Phillip Isaacson** 6. (c) Age of husband or wife if alive: **79** years

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

8. AGE: Years: **About 70** Months: Days: If less than one day: hr. min.

9. Birthplace: **Austria** // (City, town, or county) (State or foreign country)

10. Usual occupation: **At home**

11. Industry or business:

12. Name **Morris Pasternack**

13. Birthplace **Austria** // (City, town, or county) (State or foreign country)

14. Maiden name **Fannie Hauser** (State or foreign country)

15. Birthplace **Austria** // (City, town, or county) (State or foreign country)

16. (a) Informant **Phillip Isaacson**

(b) Address **1368 Arlington**

17. (a) Burial (b) Date thereof: **6-14-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **B'nai Amoona Cemetery**

18. (a) Signature of funeral director **J. F. Bredeck**
(b) Address **5216 Delmar Blvd.**

19. (a) **JUN 13 1945** **J. F. Bredeck**
(Date received local Registrar's signature) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: **June** day: **12** year: **1945** hour: **9** minute: **30 A.**

21. I hereby certify that I attended the deceased from **3-1-45**, 19... to **6-12-45**, 19... that I last saw him alive on **6-12-45**, 19... and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocardial infarction**

Due to: **Deficient diet, Glaucoma, Hypertension**

Due to:

Other conditions (include pregnancy within 3 months of death):

Major findings: Of operations: **131**

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:

(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 **R. Andrews** (M. D. or other) **6-15-45**
Address **4932 Mary Court** Date signed

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

7
9

MOTHER PARTNER

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. J. 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.