

FILED JUN 19 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5463

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 Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 44 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah Schiffer

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female
5. Color or race white
6. (e) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Jacob
6. (c) Age of husband or wife if alive years 17 1875
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days 23 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER }
12. Name Meyer Rosman
13. Birthplace Hungary
(City, town, or county) (State or foreign country)
14. Maiden name Celia Weiss
15. Birthplace Hungary
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel Schiffer
(b) Address 7436 Tulane, University City
17. (a) burial (b) Date thereof 6-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bnai Amoona

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

19. (a) JUN 12 1945 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5540 Pershing
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1945 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from March 12 1945 to June 10 1945
that I last saw her alive on June 10 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Due to General carcinoma
Carcinoma of stomach

Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy none

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 Samuel Hemenway (M. D. or other)
Address No. Fleetster Oldy Date signed 6-11-45

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..... 

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.