U. S. No. 2
00M—2-43
Rev. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

Registration District No. 39

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21287

Primary Registration District No. 3063

Registrar's No. 1536

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: St. Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 7518 Cromwell
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 96

(c) City or town: Clayton
(If outside city or town limits, write "RURAL")

(d) Street No.: 7518 Cromwell
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Bessie Katz

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: Fem. 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: Meyer Katz

6. (c) Age of husband or wife if alive ..... years

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

8. AGE: Years: About 52 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace: St. Louis, (City, town, or county) Missouri 1 (State or foreign country)

10. Usual occupation: At home

11. Industry or business .....

FATHER
12. Name: Unknown
13. Birthplace: (City, town, or county) Russia 6 (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: (City, town, or county) Russia 6 (State or foreign country)

16. (a) Informant: Mrs. Clara Shapiro
(b) Address: 7518 Cromwell

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6 13 45 (Month) (Day) (Year)
(c) Place: burial or cremation: Chesed Shel Emeth Cem.

18. (a) Signature of funeral director: H. Rundstopf
(b) Address: 5216 Delmar Blvd.

19. (a) JUN 13 1945 (Date received local registrar) (b) E. E. McEwen, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11 year 1945 hour 9 minute a.m.

21. I hereby certify that I attended the deceased from 4/11/42 to 6/8/45, 19..., that I last saw h alive on 6/8/45, 19..., and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypertensive & Arterio-sclerotic Heart Disease	3-4 yr
Due to: Hypertension	?
Due to: 93d	
Other conditions (Include pregnancy within 3 months of death): —	
Major findings: Of operations: —	
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: Arthur E. Strauss (M. D. or other)
Address: 539 N. Grand Date signed: 6/8/45

(Licensed Embalmer's Statement on Reverse Side)

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. E. Burgess

Licensed Embalmer No. 4028

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.