

FILED JUL 28 1945
818

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4605 Lindell Blvd
(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
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17 12
(d) Street No. 4605 Lindell Blvd
(If rural, give location) 9
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Jane Elizabeth Levy

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

4. Sex F. / 5. Color or race W. 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased June 2 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 1 7 hr. min.

9. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name Lester Harold Levy

13. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Ina Mae Aronberg

15. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Chris Aronberg

(b) Address 4605 Lindell Blvd

17. (a) Burial (b) Date thereof 7/10/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer

(b) Address 4356 Lindell Blvd

19. (a) JUL 10 1945 (b) J. F. Bredebeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th year 1945 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from June 10 1945 to July 9 1945

that I last saw her alive on July 7 1945 and that death occurred on the date and hour stated above. 1945

Immediate cause of death Suffocation from blood clot in trachea & bronchia following Hemorrhage in upper respiratory tract. Cause unknown
Due to.....
Due to.....

Duration

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

Of autopsy Same as above Autopsy performed at Mt. Sinai

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 Maurice Fenwick (M. D. or other) 0
Address 3720 Washington Date signed 7/19/45

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. W. Wilkins

Licensed Embalmer No.....

3575

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.