S. No. 2
DM—2-43
v. 5-17-39
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22515

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 20 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6121

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

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: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 37 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0 00
(c) City or town St. Louis 11 24
(If outside city or town limits, write "RURAL")
(d) Street No. 3118a Chippewa
(If rural, give location)
(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Minnie Sanders

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female 1

5. Color or race white

6. (a) Single, widowed, married, divorced married 1

6. (b) Name of husband or wife Louis Sanders

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

7. Birth date of deceased September 15, 1895
(Month) (Day) (Year)

8. AGE: Years 49 Months 9 Days 28 If less than one day hr. min.

9. Birthplace Roumania 6
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Wolf Schwartz
13. Birthplace Roumania 6
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Fruma Rachel Karner
15. Birthplace Roumania 6
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Sanders
(b) Address 3118a Chippewa

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7/15/45
(Month) (Day) (Year)
(c) Place: burial or cremation Hevre Kedisha

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

19. (a) JUL 15 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 13 day
year 1945 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from 3-24-44, 19, to July 13, 1945
that I last saw her alive on July 13, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Peritonitis	
Due to Carcinoma Ileo. Cecal Ileo	
Due to	
Other conditions (Include pregnancy within 3 months of death) 46	
Major findings: Of operations 3-30-44 Carcinoma Ileum + Cecum	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Harry Landy (M. D. ~~or other~~)
Address 634 N. Grand Date signed 7/14/45

(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.....

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.