S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

F 08080

25625

State File No.

FILED SEP 1 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 22273

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:
Jewish Hos'p
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community 30 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St Louis 96

(c) City or town ~~St. Louis~~ Jennings City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 6331 Delmar Ave 5
(If rural, give location)

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

3. (a) PRINT FULL NAME Yetti Feiner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 1 5. Color or race White 6. (a) Single, widowed, married, divorced Wid. 2

6. (b) Name of husband or wife David Feiner

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

7. Birth date of deceased May (Month) 4 (Day) 1868 (Year)

8. AGE: Years 77 Months 3 Days 15 If less than one day hr. min.

9. Birthplace (City, town, or county) Poland (State or foreign country) 4

10. Usual occupation at home

11. Industry or business

MOTHER FATHER

12. Name Solomon Barber

13. Birthplace (City, town, or county) Poland (State or foreign country) 4

14. Maiden name Helene Feiner (Cousins)

15. Birthplace (City, town, or county) Poland (State or foreign country) 4

16. (a) Informant Miss Lenor Feiner

(b) Address 6331 Delmar Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive (Jewish)

18. (a) Signature of funeral director Mayer

(b) Address 4356 Lindell Blvd

19. (a) AUG 20 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 19 th year 1945 hour 5:15 minute P. M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....;
that I last saw h..... alive on ....., 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia	48 hrs
Due to: Malnutrition	2 yrs
Hyperthyroidism	3 yrs
Due to: Hypertonic Heart Disease	3 yrs
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Mona Alex M. D. (M. D. or other)

Address Jewish Hospital Date signed 8/20/45

(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.....

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.