S. No. 2
M—2-43
5-17-39
I X35697

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

FILED SEP 7 1945

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25796

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7408

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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days (Specify whether
In this community 41 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 96

(c) City or town University City N.R. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 7371 Amherst 5
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Jackoway - Zelda

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Late Joseph Jackoway

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

7. Birth date of deceased Sept (Month) 15 (Day) 1882 (Year)

8. AGE: Years 62 Months 11 Days 9 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Housework

FATHER
12. Name Mosha Kuppel Seigel
13. Birthplace (City, town, or county) Russia (State or foreign country)

MOTHER
14. Maiden name Chontza Horwitz
15. Birthplace (City, town, or county) Russia (State or foreign country)

16. (a) Informant Mrs. Sara Lee Schneider
(b) Address 7371a Amherst

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Osenhandler
(b) Address 4469 Washington

19. (a) AUG 26 1945 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24 year 1945 hour 3 minute P M.

21. I hereby certify that I attended the deceased from 8-15, 1945, to 8-24, 1945; that I last saw her alive on 8-24, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchopneumonia	3 days
Due to Diabetic Coma	10 days
Due to Fracture of humerus at Humerus	20 days
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

186
18

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) Accident fell

(b) Date of occurrence Aug 4 1945

(c) Where did injury occur? Home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? no (e) Means of injury fell.

23. Signature M. Norman Orgel (M. D. or other) M.D.

Address 634 No. Grand, St. Louis Date signed 8-25-45

(Licensed Embalmer's Statement on Reverse Side)

Feb 5937

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. J. Benhandler

Licensed Embalmer No. 3669

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.