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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

FILED AUG 24 1945

State File No. 26101

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7245

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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 664
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5370 Pershing 9 12
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ray Schiele

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 Widow 91

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

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

8. AGE: Years 65 About ~~64~~ Months - Days — If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Jacob Epstein
13. Birthplace Stuttgart (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Sophie Jacoby
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Raymond Jacoby
(b) Address Owensville Ky.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Sinai Cemetery

18. (a) Signature of funeral director Herman Lindskopf
(b) Address 5216 Delmar Blvd.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 18 year 1945 hour 9:30 minute A M.

21. I hereby certify that I attended the deceased from Jan 1940 to Aug 1945 that I last saw him alive on Aug 18 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of Uterus	3 yrs.
Inclusion of Colon	1 yr.
Due to Intestinal Obstruction	48 hrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

48 hrs

Major findings:
Of operations as above
Of autopsy not done

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 [signature] (M. D. or other)
Address Euclid Politan Bldg Date signed 8/14/45

(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. 4029

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.