S. No. 2
OM—5-43
v. 5-17-39
» I X38671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29274

FILED SEP 28 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8133

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: 5918a Bartmer ave. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 32 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ooo

(c) City or town St. Louis 17 5
(If outside city or town limits, write "RURAL")

(d) Street No. 5918a Bartmer ave. 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Anna Morgensteren

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female/ 5. Color or race white 6. (a) Single, widowed, married, divorced married/

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

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

8. AGE: Years about 66 Months Days If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Moses Finkelstein
13. Birthplace (City, town, or county) Poland 4 (State or foreign country)

MOTHER
14. Maiden name Fanny (unk)
15. Birthplace (City, town, or county) Poland 4 (State or foreign country)

16. (a) Informant A. Morgensteren
(b) Address 5918a Bartmer

17. (a) burial 5 (Burial, cremation, or removal) (b) Date thereof 9/19/45 (Month) (Day) (Year)

(c) Place: burial or cremation Beth Ham Hag.

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

19. (a) SEP 18 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 16
year 1945 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from February, 1940, to Sept. 16, 1945
that I last saw her alive on Sept. 16, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis, Chronic Myocarditis — Duration: sudden, 10 years

Due to: Coronary Sclerosis, Hypertension

Due to: Chronic Nephritis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 131

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 Max Goldenson (M. D. ~~or other~~)

Address Metropolitan Bldg. Date signed 9/18/45

(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.