

FILED OCT 19 1945
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8795

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 St. Louis Children's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day - 60 hrs.
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 5877 MAFFITT
(If rural, give location)
(e) Citizen of foreign country? _____
(Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Judith Gale Gold

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 1

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

7. Birth date of deceased June 24 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 3 4 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name MILTON GOLD
13. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)
14. Maiden name SABIE VETNIKOFF
15. Birthplace MONTREAL CANADA
(City, town, or county) (State or foreign country)

16. (a) Informant Milton Gold
(b) Address 5877 Maffitt

17. (a) BURIAL (b) Date thereof 10-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesad Shel Emet H

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

19. (a) OCT 11 1945 (b) J. J. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1945 hour 6 minute 55 A.M.

21. I hereby certify that I attended the deceased from October 9
1945 to October 11 1945;
that I last saw her alive on 10-11 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Intussusception
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. J. Blotner (M. D. or other) _____
Address 501 S. Kingshighway Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

20
17
9

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. B. Penhander*.....

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.