

V. S. No. 2
FORM-5-43
Rev. 5-17-39
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35609

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

10507

FILED DEC 12 1945
Registration District No. 318

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis

(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 years, months or days) 37 years

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 3232 Pine
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Ida Margolin

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

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

7. Birth date of deceased September 15, 1894
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 3
year 1945 hour 12:15 minute _____ P.M.

21. I hereby certify that I attended the deceased from Oct 1
1945 to Dec 2 1945

that I last saw her alive on December 2, 1945
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>2</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death Carcinoma of Ovary

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) HA

Major findings: Of operations Carcinoma of Ovary

Of autopsy none

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation merchant

11. Industry or business candy and delicatessen

12. Name Jacob Lowman

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

14. Maiden name Sarah Leah (unknown)

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

16. (a) Informant Sol Margolin
(b) Address 1226 Bellevue, Richmand Hgts

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-4-45
(Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

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

19. (a) DEC 4 1945 (Date received local registrar) J. F. Bedeck (Registrar's signature)

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) Means of injury _____

23. Signature J. F. Bedeck (M. D. or other) _____
Address 12th Bedg Date signed 12/3/45

(Licensed Embalmer's Statement on Reverse Side)

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

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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. H. Bergin
.....
Licensed Embalmer No. 1097

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.**