

S. No. 2
M-5-43
v. 5-17-39
I X36671

FILED NOV 26 1945
Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1632

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Shamrock Rest Home 4
(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)

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

3. (a) PRINT FULL NAME Rachel Faier

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 2

6. (b) Name of husband or wife Morris Faier

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

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

8. AGE: Years about 74 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Abraham Schloma Rosenrib

{ 13. Birthplace Poland 4
(City, town, or county) (State or foreign country)

{ 14. Maiden name Rebecca (unk)

{ 15. Birthplace Poland 11
(City, town, or county) (State or foreign country)

16. (a) Informant I. Faier

(b) Address 734 Leland

17. (a) burial (b) Date thereof 11-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson ave.

19. (a) 11-20-45 (b) E. J. McPherson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 000

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

(d) Street No. 2602nd N. Union 9
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17
year 1945 hour 7 minute 40 P. M.

21. I hereby certify that I attended the deceased from June 8, 1945, to Nov. 17, 1945.

that I last saw him alive on 11-17, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 6 wks

Due to 94a

Due to arteriosclerosis many years

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

Major findings:
Of operations _____

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? _____

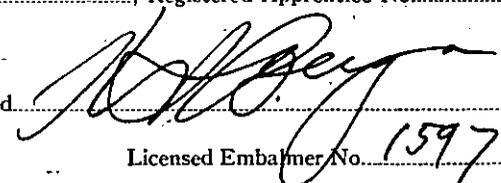
While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature Joseph McPherson (M. D. or other) MD
Address 520 Westgate Date signed 11-15-45

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. 1597

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.