

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

38547  
State File No. 8  
Registrar's No. 2588

Registration District No. 312 Primary Registration District No. 2002

76  
3  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town University City  
(c) Name of hospital or institution: 7009 Cornell Ave. /  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 96  
(c) City or town University City 3  
(d) Street No. 7009 Cornell 5  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Gizella Loewenstein

MEDICAL CERTIFICATION

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Nov. day 7 year 1945 hour 11:45 minute P M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

21. I hereby certify that I attended the deceased from Jasany 12, 1932, to Nov 7, 1945; that I last saw her alive on Nov 7, 1945; and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife Julius Loewenstein 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

Immediate cause of death Coronary thrombosis Duration 1/2 hr

8. AGE: Years Months Days If less than one day  
about 60 -- -- .hr. min.

Due to generalized arterio sclerosis many years of age

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

Due to \_\_\_\_\_

10. Usual occupation at home

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

MOTHER, FATHER { 12. Name Samuel Weiss

Of autopsy \_\_\_\_\_

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

PHYSICIAN Underline the cause to which death should be charged statistically.

14. Maiden name Jeanette Preissack

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

16. (a) Informant Erwin M. Loewenstein  
(b) Address 7009 Cornell

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-1945  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cemetery

18. (a) Signature of funeral director Heinrich Bindschopf  
(b) Address 5216 Delmar Blvd.

19. (a) 11-10-45 (Date received local registrar) (b) E. M. M. Danner, M.D. (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) (c) Means of injury \_\_\_\_\_

23. Signature Joseph Meijlson (M. D. or other) med.  
Address 510 W. 1st St. Date signed 11-9-45

FEB 27 1946

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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. E. Burgess*

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.