

S. No. 2
DM-2-43
v. 5-17-39
X35697

3999

DEPARTMENT OF COMMERCE
BUREAU OF CERTIFICATION
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 6276

Registrar's No. 233

1. PLACE OF DEATH:

(a) Country St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 54 days
(Specify whether)

In this community 12 months
(Year, month 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. 1931 Burd
(If rural, give location)

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

3. (a) PRINT FULL NAME JACOB GOLDIEZ

(b) If veteran, name war 40

(c) Social Security No. 494-26-3991

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23
year 1946 hour 12 minute 07 A.M.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife NEEDE Goldberg Goldiez

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

7. Birth date of deceased 1 19 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-30- 1945 to 1-23 1946
that I last saw him alive on 1-23- 1946
and that death occurred on the date and hour stated above.

8. AGE: Years 58 Months - Days 4
If less than one day _____ hr. _____ min.

Immediate cause of death Arteriosclerotic Heart Disease ?

Duration _____

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

10. Usual occupation Welder

Due to _____

Due to _____

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

11. Industry or business PEREL

12. Name Albert Goldiez

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

14. Maiden name Mary Friedman

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

Major findings: Of operations _____

Of autopsy _____

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

16. (a) Informant Hospital Records

(b) Address Koch Hospital, Koch, Mo.

17. (a) Burial (b) Date thereof 1/25/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth Berger Memorial

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson Ave

19. (a) 1-26-46 (b) Ed M. Saran MD
(Date received local registrar) (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? _____

(Specify type of place) _____

While at work? _____ (c) Means of injury _____

23. Signature Reinhold Eusterman MD (M.D. or doctor)
Address Koch, Missouri Date signed 1-23/46

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

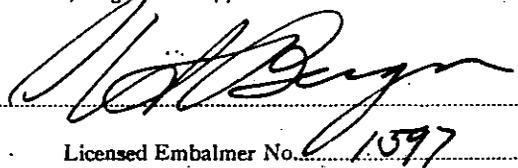
76
0
2709

MAY 4 1949

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.