

S. No. 2
DM-5-43
v. 5-17-39
I X38671

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

10649

State File No.

646

Registrar's No.

FILED MAR 27 1946
317
Registration District No.

3069
Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

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

In this community _____
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. 902 N. Kingshighway
(If rural, give location)

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

3. (a) PRINT FULL NAME BELLA FISHER GALLANT

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17
year 1946 hour 7:35 minute _____ P. M.

21. I hereby certify that I attended the deceased from
March 12, 1946 to March 17, 1946;
that I last saw her alive on March 17, 1946;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Max Gallant

6. (c) Age of husband or wife if alive 68 years

7. Birth-date of deceased Unknown
(Month) (Day) (Year)

Immediate cause of death _____
Cerebral Haemorrhage left with right side paralysis

Due to Broncho Pneumonnia 18 hrs.

Due to Heart failure 11 hrs.

Other conditions Hypertension Cardio vascular disease
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	<u>About 63</u>			hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Abraham Fisher

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

14. Maiden name Mollie Albin

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

Major findings: _____

Of operations: None

Of autopsy: None

16. (a) Informant Max Gallant

(b) Address 902 N. Kingshighway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46
(Month) (Day) (Year)

(c) Place: burial or cremation Beth Hamedrosh Hagodol

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? _____

18. (a) Signature of funeral director H. Rindskopf

(b) Address 5216 Delmar Blvd.

19. (a) 3-19-46 (Date received local registrar)

(b) R.M. Danaher (Registrar's signature)

23. Signature James E. ... (Specify type of place) (c) Means of injury _____ (M. D. or other) _____

Address 1004 ... Date signed 3/18/46

(Licensed Embalmer's Statement on Reverse Side)

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

9561

MAR 29 1944

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..... *J. P. 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.