

S. No. 2  
M-543  
7. 5-17-39  
I X36671

24763

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

State File No. 2

**FILED** 16 1946  
Registration District No. 317

Primary Registration District No. 8063

Registrar's No. 1417

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

**1. PLACE OF DEATH:**

(a) County St Louis

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

(c) Name of hospital or institution:  
HOME - 52 BROADVIEW  
(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 MO (b) County St Louis <sup>96</sup>

(c) City or town CLAYTON <sup>2</sup>  
(If outside city or town limits, write "RURAL.")

(d) Street No. 52 Broadview <sup>3</sup>  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** ESTHER GROSSMAN

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month July day 5  
year 1946 hour 6 minute 45 a.m.

21. I hereby certify that I attended the deceased from April 18, 1942 to July 5, 1946  
that I last saw h. alive on July 5, 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 widowed

6. (b) Name of husband or wife MORRIS GROSSMAN 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 <sup>2 weeks</sup>

Due to arteriosclerosis <sup>many</sup>

Due to generalized - 94 <sup>yr old</sup>

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

**8. AGE:** Years Abt 83 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_  
hr. min.

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

10. Usual occupation HOUSEWORK

11. Industry or business HOUSEWIFE

12. Name Jacob

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

14. Maiden name BOB SLE

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

16. (a) Informant Mrs. Ben Diamond

(b) Address 52 Broadview

17. (a) BURIAL (b) Date thereof 7-5-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chapel Shgl EPIETH

18. (a) Signature of funeral director [Signature]

(b) Address 4469 W B Shreve St

19. (a) 7-6-46 (b) E. N. McDevaney  
(Date received local registrar) (Registrar's signature)

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

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

**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 \_\_\_\_\_

(i) Signature Joseph Magidom (M. D. or other) MD  
Address 520 Walnut Date signed 7/5/46

5-16-46

JUL 17 1946

**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.....

working under my personal supervision. *Not Embalmed*

....., Registered Apprentice No.....

Signed *J. B. [Signature]*

Licensed Embalmer No. *3669*

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.