

FILED AUG 5 1946

318

STANDARD CERTIFICATE OF DEATH

State File No.

1003

Registrar's No. 6517

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis 96**
(c) City or town **St. Louis** **Universal City 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **6623 Clemens Ave.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) **1**
If yes, name country

3. (a) PRINT FULL NAME **Zanetta Levy**

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

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

6. (b) Name of husband or wife **Robert Levy** 6. (c) Age of husband or wife if alive **April 2, 1861** years

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

8. AGE: Years Months Days If less than one day
85 3 21 hr. min.

9. Birthplace **St. Louis, Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business

12. Name **Sol J. Levi**

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

14. Maiden name **Matilda Johnson** (City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs. Matilda Scholer**

(b) Address **6623 Clemens Ave.**

17. (a) **Burial** (b) Date thereof **7-25-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
Mt. Olive Cemetery

(c) Place: burial or cremation

18. (a) Signature of funeral director: **Herman Rindberg**

(b) Address **5216 Delmar Blvd.**

19. (a) **JUL 24 1946** (b) **J. F. Bredel**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **23**
year **1946** hour **4** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **May**
19 **46** to **July 23** 19 **46**
that I last saw her alive on **July 23** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia** Duration **1 mo**

Due to **72**
Due to

Other conditions **Chronic myocarditis Sev. yrs**
(Include pregnancy within 3 months of death)

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?

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

23. Signature **P.D. Stahl MD** (M. D. or other)
Address **462 N. Taylor Ave** Date signed **7/24/46**

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

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.