

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25769
5860
Registrar's No.

FILED JUL 16 1948
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County St. Louis
(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

3. (a) PRINT FULL NAME Rose Strum
3. (b) If veteran, name war Nil
3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Ben Strum
6. (c) Age of husband or wife if alive Unk. years
7. Birth date of deceased February Unk. 1877
(Month) (Day) (Year)

8. AGE: Years 69 Months ? Days ?
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown Tober
13. Birthplace Unknown Russia
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Russia
(City, town, or county) (State or foreign country)

16. (a) Informant Sam White
(b) Address 716 S. Meramac St.

17. (a) Removal (b) Date thereof 7-2-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) JUL 2 1948 J. F. Brudick
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Clayton
(If outside city or town limits, write "RURAL")
(d) Street No. 716 S. Meramac St.
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2
year 1946 hour minute M.
21. I hereby certify that I attended the deceased from May 1943
19 to July 2, 1946
that I last saw her alive on July 1, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Heart failure
Due to metastatic carcinoma
severe secondary anemia
Due to Cancer of ovary - Primary site
Other conditions (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Related carcinoma
Of operations Carcinoma
Of autopsy
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 M. D. Taylor (M. D. or other) M.D.
Address 462 N. Taylor Date signed 7/3/46

0966

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..... *Albert G. Kopp*
Licensed Embalmer No..... *2971*
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.