

FILED JAN 23 1947

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

164

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 \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5531 Pershing  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Barbara Mae Coppersmith

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 Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 4 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
2 9 2 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Ben Coppersmith  
13. Birthplace Russia  
(State or foreign country)

14. Maiden name Sophie Schwartz  
15. Birthplace Russia  
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Coppersmith  
(b) Address 5929 Hamilton Terrace

17. (a) Burial (b) Date thereof 1-7-1947  
(Burial, cremation, or removed) (Month) (Day) (Year)  
(c) Place: burial or cremation Chesed Shel Emeth Cem.

18. (a) Signature of funeral director German [unclear] (Specify type of place) \_\_\_\_\_  
(b) Address 5216 Delmar Blvd. (c) Means of injury \_\_\_\_\_

19. (a) JAN 7 1947 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)  
23. Signature Lawrence Goldman (M. D. or other) M.D.  
Address 1111 [unclear] Date signed 1/7/47

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6  
year 1947 hour \_\_\_\_\_ minute 00 M.

21. I hereby certify that I attended the deceased from Jan 4th  
1947 to Jan 6 1947  
that I last saw him alive on Jan 6 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Bacterial pneumonia  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Toxic Encephalitis  
(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? \_\_\_\_\_

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

MOTHER FATHER

---

---

**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.**