

No. 2
-12-45
5-17-39
1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3162

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **682**

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 **2 days** (Specify whether
In this community **50 years** 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. **808 Eastgate** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Rachel (Rose) Stein**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Peter Stein** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 82 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

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

16. (a) Informant **Dave Stein**
(b) Address **560 Purdue**

17. (a) **Burial** (b) Date thereof **1/21/1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Chesed Shel Emeth Berger Memorail**

18. (a) Signature of funeral director **4715 McPherson Avenue**
(b) Address

19. (a) **JAN 21 1947** (b) **J. J. Bredbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **20**
year **1947** hour **3:00** minute **am** M.

21. I hereby certify that I attended the deceased from **Jan 17**
1947 to **Jan 20** 19**47**
that I last saw h **er** alive on **Jan 20** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis**
myocardial infarction
arteriosclerosis
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **GH**
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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?

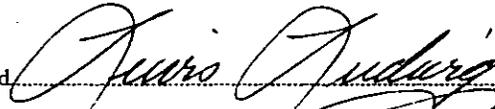
While at work? _____ (Specify type of place) (e) Means of injury _____
Signature **Edward Masnie** (M. D. or other) **0**
Address **607 N. Grand** Date signed **1/21/47**

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.....



Licensed Embalmer No.....

4229

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.