

No. 2
12-45
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X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11402**
Registrar's No. **3587**

FILED APR 14 1947

Primary Registration District No. **1003**

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

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:
4631 Washington
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... **20 yrs**
(Specify whether 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..... **4631 Washington**
(If rural, give location)

(e) Citizen of foreign country?..... **No** (Yes or No) **0**
If yes, name country.....

3. (a) PRINT FULL NAME **SARAH POMERANCE (aka Sadie Pomerance)**

3. (b) If veteran, name war..... **No**

3. (c) Social Security No..... **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr.** day **3rd**
year **1947** hour **7** minute **30** P.M.

21. I hereby certify that I attended the deceased from **2/25/1947**
to **4/3/47**
that I last saw her alive on **4/3/47**
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 Pomerance**

6. (c) Age of husband or wife if alive..... years

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

Immediate cause of death **Cerebral Hemorrhage** Duration **2 W/KS**

Due to **Hypertension (Arterial) Congestive Heart Failure**

Due to **Hypostatic Pneumonia**

8. AGE: Years Months Days If less than one day

ab. 80 **1** **7** **hr. min.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations..... **82**

Of autopsy..... **None**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10. Usual occupation..... **at home**

11. Industry or business.....

MOTHER FATHER

12. Name..... **(unknown)**

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

14. Maiden name..... **(unknown)**

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

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?.....

16. (a) Informant **Joseph Goodman**

(b) Address **650 S. Detroit, LaCalif**

17. (a) **burial** (b) Date thereof **4/4/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **B'Nai Amoona**

18. (a) Signature of funeral director..... **Berger Memorial**

(b) Address..... **4715 McPherson**

19. (a) **APR 4 1947** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place)

(c) Means of injury..... **0**

23. Signature **Raymond M. Spury** (M. D. or other) **4/4/47**
Address **Revermont Hotel, 1209** Date signed.....
3720 Washington

will

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 *Julio A. Gudiño*
Licensed Embalmer No. *4529*

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.