

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 4 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

32276
State File No. _____
Registrar's No. 8862

Registration District No. 318 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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME HATTIE ABRAMSON
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: Jack Abramson
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 68 hr. min.

9. Birthplace: Alsace Lorraine
(City, town, or county) (State or foreign country)

10. Usual occupation: At home

11. Industry or business _____

MOTHER FATHER { 12. Name: Benjamin Levy
13. Birthplace: France
(City, town, or county) (State or foreign country)

{ 14. Maiden name: Josephine Meyer
15. Birthplace: France
(City, town, or county) (State or foreign country)

16. (a) Informant: Alvin W. Abramson

(b) Address: 5733 Kingsbury

17. (a) Burial (b) Date thereof: 9-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Sinai Cemetery

18. (a) Signature of funeral director: _____
(b) Address: 5216 Delmar Blvd.

19. (a) SEP 22 1947 (b) J. F. Briedack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County one
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5733 Kingsbury 9
5 (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1947 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 7
1947 to Sept 20 1947
that I last saw her alive on Sept 20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion
arteriosclerotic heart disease five years

Due to _____
Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: Coronary occlusion
arteriosclerotic heart disease

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

23. Signature: Herman M. Meyer (M. D. or other) MD.
Address: 508 N. Grand Date signed: 9/22/47

Duration

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

John Ketter
.....
Licensed Embalmer No. *3880*

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.

Registration District No. 318

Primary Registration District No. 1003

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:

(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)

3. (a) PRINT FULL NAME Halter abramson

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

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

8. AGE: Years Months Days If less than one day
att 68 hr. min.

9. Birthplace Palmer, Ill
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

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

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 9-22-47 (b) J. F. Bredeok
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to..... 19.....
that I had seen..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
(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?

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

23. Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

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

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