

Registration District No. **318**Primary Registration District No. **1008**

## 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: **Missouri-Pacific**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution..... **2 wks.**  
 (Specify whether  
 In this community..... **65 yrs.**  
 years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **St. Louis** **96**  
 (c) City or town..... **University City** **3**  
 (If outside city or town limits, write "RURAL") **5**  
 (d) Street No..... **616 Eastgate**  
 (If rural, give location)  
 (e) Citizen of foreign country?..... **No.** (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **15**  
 year..... **1948** hour..... **4:30** minute..... P. M.

21. I hereby certify that I attended the deceased from **Dec 1, 1947**  
 to **Jan 15, 1948**  
 that I last saw him..... **or** **Jan 15, 1948** alive on.....  
 and that death occurred on the date and hour stated above. **Jan 15, 1948**  
 Duration

Immediate cause of death..... **Cerebrovascular episode** **2 wks.**  
**Hemiplegia, left** **2 wks.**

Due to..... **arteriosclerosis**  
 Due to..... **senility**

Other conditions..... **832**  
 (Include pregnancy within 3 months of death)

Major findings:..... **02**  
 Of operations.....  
 Of autopsy.....

## 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..... **D-**

23. Signature..... **R. C. Sherman** (M. D. or **D-**)  
 Address..... **6233 Delmer** Date signed..... **1/16/48**

3. (a) PRINT FULL NAME **Fanny Finkelstein**

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

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

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

9. Birthplace..... **Russia** **1a**  
 (City, town, or county) (State or foreign country)

10. Usual occupation..... **At home**

11. Industry or business.....

12. Name..... **(unk) Shanfeld**

13. Birthplace..... **Russia** **6**  
 (City, town, or county) (State or foreign country)

14. Maiden name..... **Mollie (unk)**

15. Birthplace..... **Russia** **6**  
 (City, town, or county) (State or foreign country)

16. (a) Informant..... **Mrs. Sara Kreisman**

(b) Address..... **616 East Gate**

17. (a) Burial..... (b) Date thereof..... **1/16/48**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Chesed Shel Emeth**

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

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

19. (c) Date received..... **JAN 16 1948** (d) Signature..... **J. F. Brudnick**  
 (Date received) (Registrar's signature)

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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 Lewis R. Ludwig  
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.

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

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.....

3. (a) PRINT FULL NAME Fanny Finkelstein

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

4. Sex F 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 (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

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) 1-16-48 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-15  
year 1948 hour 1 minute 5 M.

21. I hereby certify that I attended the deceased from..... to....., 19.....  
that I last saw him..... 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.....

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

SUPPLEMENTARY

FEB 26 1948

S-2500 1948