

1/47
17-39

FILED OCT 4 1948

Registration District No. **27**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH: **St. Louis**

(a) County: **St. Louis**

(b) City or town: **Rural: cannot town**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **JEWISH SANATORIUM**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: **4 weeks, 25 days**
(Specify whether years, months or days)

In this community: **4 weeks, 25 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.: **3913 LaFayette Ave.**
(If rural, give location)

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

3. (a) PRINT FULL NAME: **Rose Kotner**

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: **Israel Kotner**

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 73 hr. min.

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

10. Usual occupation: **At home**

11. Industry or business: _____

MOTHER FATHER { 12. Name: **Morris Jacobs**

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)

16. (a) Informant: **Joel M. Jacobs**

(b) Address: **St. Charles, Mo.**

17. (a) **Burial** (b) Date thereof: **9-16-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director: **Herman Rindskopf, Inc**
5216 Delmar Blvd.

(b) Address: _____

19. (a) **9/15/48** (b) **Carl A. Z. Sharp, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **15** year **1948** hour **12** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **April 20**, 19**48**, to **September 15**, 19**48**, that I last saw her alive on **Sept 14**, 19**48**, and that death occurred on the date and hour stated above.

Duration: **about 1 year**

Immediate cause of death: **Cancer of rectum**

Due to: **Hypertrophic arthritis**

Due to: **46d**

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

Major findings: _____
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: _____

23. Signature: **John H. ...** (M. D. or other)
JEWISH SANATORIUM

Address: **ROUTE 1 BOX 410** Date signed: **9-15-48**

PHYSICIAN
Underline the cause of 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 _____

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.