

MISSOURI DIVISION OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

37922  
 State File No. \_\_\_\_\_  
 Registrar's No. **10363**

**FILED DEC 8 1948 318**  
 Registration District No. \_\_\_\_\_

Primary Registration District No. **1005**

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

**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 \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

**3: (a) PRINT FULL NAME** HELENA BRUCKSTEIN  
 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 Max Bruckstein  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Unknown  
 (Month) (Day) (Year)

**8. AGE:** Years About 68 Months - Days -  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

**10. Usual occupation** At home

**11. Industry or business** Unknown

**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)

**16. (a) Informant** Mrs. Paul D. Kranzberg

**(b) Address** 7615 Maryland Ave.

**17. (a) Burial** Burial (b) Date thereof 11-30-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt. Sinai Cemetery

**18. (a) Signature of funeral director** Herman Rindskopf, Inc.  
5218 Delmar Blvd.  
 (b) Address

**19. (a) NOV 29 1948** (b) J. B. Labster  
 (Date received local registrar) (Registrar's signature)

**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. 5315 Pershing Ave.  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Nov. day 28  
 year 48 hour 1 P.M. minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** November  
17, 1948, to Nov 28, 1948  
 that I last saw her alive on Nov. 28, 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia due  
to  
leucocytosis.  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

**Major findings:**  
 Of operations \_\_\_\_\_  
 Of autopsy Report not available yet.  
**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)  
 (c) Means of injury \_\_\_\_\_

**23. Signature** J. B. Labster (M. D. or other)  
 Address 11th St. St. Louis Date signed 11/29/48

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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 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.**