

FILED AUG 2 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25729

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6096</u>		Registrar's No. <u>1708</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis Mo</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural: Airport Township</u>		c. LENGTH OF STAY (in this place) <u>3 years 4 months</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		TOWN <u>4</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>JEWISH SANATORIUM Robertson Mo</u>				d. STREET ADDRESS (If rural, give location) <u>1438 E Grand</u>			
3. NAME OF DECEASED (Type or Print), <u>MIRRIE</u>		a. (First)		b. (Middle)		c. (Last) <u>STEIN</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>July 18 1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	
8. DATE OF BIRTH <u>unk</u>		9. AGE (In years last birthday) <u>abt 71</u>		if UNDER 1 YEAR Months		if UNDER 1 YEAR Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Philip Hamburger</u>		13b. MOTHER'S MAIDEN NAME <u>Unk</u>		14. NAME OF HUSBAND OR WIFE <u>Philip</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. F. Feir 1368 E. 94th Brooklyn</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>  <u>many years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 28, 1946</u> , to <u>July 18, 1949</u> , that I last saw the deceased alive on <u>July 18, 1949</u> , and that death occurred at <u>8:30 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Abig. Amore M.D.</u>				23b. ADDRESS <u>Jewish Sanatorium Fee Fee Road, Robertson, Mo.</u>		23c. DATE SIGNED <u>7.18.49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/19/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>B'nai Amoona</u>		24d. LOCATION (City, town, or county) (State) <u>University City Mo</u>	
DATE REC'D BY LOCAL REG. <u>7-19-49</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Sanchez</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Berger Memorial 8715 McPherson</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-4896  
y

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Lewis L 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.