

FILED SEP 2 1949

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

State File No. 27879
7187

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY		
b. CITY OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place) 35 yrs	c. CITY OR TOWN ST. LOUIS		
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Old Folks Home			d. STREET ADDRESS 9-1438 E Grand		
3. NAME OF DECEASED (Type or Print) Bessie		a. (First) 1938	c. (Last) BORNSTEIN		4. DATE OF DEATH (Month) (Day) (Year) Aug. 29 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH unk	9. AGE (In years, last birthday) 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Langbad		13b. MOTHER'S MAIDEN NAME unk	
14. NAME OF HUSBAND OR WIFE Thom		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		_____			_____
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____			_____
		DUE TO (c) _____			_____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

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) 97	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1943 4221	

22. I hereby certify that I attended the deceased from Aug 1, 1948 to Aug 29, 1949 that I last saw the deceased alive on Aug 27, 1949, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree of title) _____		23b. ADDRESS 1918 E Grand		23c. DATE SIGNED 8/29/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/29/49		24c. NAME OF CEMETERY OR CREMATORY B'nai Annon	
24d. LOCATION (City, town, or county) (State) University City, Mo		25. FUNERAL DIRECTOR'S SIGNATURE (Address) Berger Memorial 210 W. McPherson			
DATE REC'D BY LOCAL AUG 29 1949		REGISTRAR'S SIGNATURE J. B. Pasatore			

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

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 _____

Not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Signed _____

John J. Anderson

Signed _____
Student Embalmer

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.