

35116

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED NOV 5 1949

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9092

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u> )		c. LENGTH OF STAY (In this place) <u>1 day</u>	
c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>1371 Clara Avenue</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>Jewish Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARIAM</u> b. (Middle) c. (Last) <u>FELDER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 21 1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>unk.</u>
9. AGE (In years last birthday) <u>Ab. 63</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Morris Felman</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Gus Felder 1371 Clara</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Adolph Felder 1371 Clara Ave.</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage (Hypertension)</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> 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 checked="" 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) <u>102</u>			
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? <u>331X</u>			
22. I hereby certify that I attended the deceased from <u>Oct 1945</u> , to <u>Oct. 21, 1949</u> , that I last saw the deceased alive on <u>Oct 21, 1949</u> , and that death occurred at <u>1:12 m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Lawrence M. Koster M.D.</u>		23b. ADDRESS <u>508 N Grand</u>	
23c. DATE SIGNED <u>10/21/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/23/1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Hevra Kedisha</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
DATE REC'D BY LOCAL REG. <u>OCT 23 1949</u>		REGISTRAR'S SIGNATURE <u>J. C. Carter</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Berger Memorial</u>		ADDRESS <u>4715 McPherson Ave.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

**STATEMENT BY LICENSED EMBALMER**

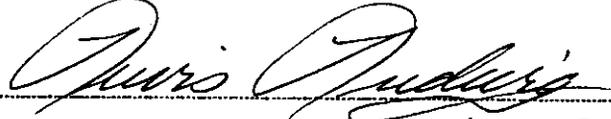
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. \_\_\_\_\_

4529

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.