

FILED APR 3 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11145**

BIRTH NO.		REG. DIST. NO. <b>317</b>	PRIMARY REG. DIST. NO. <b>6076</b>	Registrar's No. <b>659</b>
1. PLACE OF DEATH a. COUNTY <b>St. Louis Mo</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MO</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Airport Townships</b>		c. LENGTH OF STAY (in this place) <b>5 yrs</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis 2259</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>JEWISH SANATORILUM</b>		e. STREET ADDRESS (If rural, give location) <b>1817 CAR 1</b>		
3. NAME OF DECEASED a. (First) <b>Bessie</b>		b. (Middle)	c. (Last) <b>Safrop</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>3 - 13 51</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>unk</b>	9. AGE (In years last birthday) <b>40</b> IF UNDER 1 YEAR: Months Days IF UNDER 4 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>USSR 6</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>unk Steiler</b>		13b. MOTHER'S M maiden NAME <b>unk</b>	14. NAME OF HUSBAND OR WIFE <b>Theodor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Meyer Safrop 4931 Parkview</b>		
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral accident</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>cerebral arteriosclerosis</b>  DUE TO (c) <b>hypertensive and arteriosclerotic heart disease</b> Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>  <b>Known since many years</b>
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) <b>331 X</b>		
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?		
22. I hereby certify that I attended the deceased from <b>May 1, 1946</b> , to <b>March 13, 1951</b> , that I last saw the deceased alive on <b>March 13, 1951</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>John S. Moore M.D.</b>		23b. ADDRESS <b>Jewish Sanatorium Fee Fee Road, Robertson, Mo.</b>	23c. DATE SIGNED <b>3/13/51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>3/14/51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Geneva Kadasha</b>	24d. LOCATION (City, town, or county) (State) <b>Union City Mo</b>	
DATE REC'D BY LOCAL REG. <b>3/14/51</b>	REGISTRAR'S SIGNATURE <b>Robert P. Lombe M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Berger Memorial</b>	ADDRESS <b>4710 McKelvey</b>	

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

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Quiro A. Quiring*  
.....  
Licensed Embalmer No. *FE 29*

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.