

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

791  
1003

26504  
667B

1. PLACE OF DEATH  
 County..... Registration District No. ....  
 Township..... Primary Registration District No. ....  
 City Saint Louis (No. Jewish Hospital) St. .... Ward)  
 2. FULL NAME Manuel Rosenthal  
 (a) Residence, No. 1342 Temple St., ..... Ward. (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nellie Daniel Rosenthal  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 4, 1901  
 7. AGE YEARS 32 MONTHS 8 DAYS 1 IF LESS than 1 day, ..... hrs. or ..... min.  
 8. Trade, profession, or particular kind of work done, as planer, sawyer, bookkeeper, etc. Mechanic  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Retail  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Newark N.J.  
 13. NAME Reubin Rosenthal  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia  
 15. MAIDEN NAME Fanny (Unkerson)  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) none  
 17. INFORMANT (ADDRESS) Mrs. Nettie Daniel Rosenthal 1342 Temple  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Beth Ham N.Y. DATE 7-6-34  
 19. UNDERTAKER (ADDRESS) H. B. Brown 47 715 McAdams  
 20. FILED - 61334 19 34

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 5, 1934  
 I HEREBY CERTIFY That I attended deceased from July 3, 1934 to July 4, 1934  
 I last saw him alive on July 4, 1934 Death is said to have occurred on the date stated above, at 29 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Acute Glomerular Nephritis (Cause unknown) 4/4/34  
Uremia  
 Other contributory causes of importance: 130  
 Name of operation..... Date of.....  
 What test confirmed diagnosis? urine analysis Was there an autopsy? No  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury.....  
 Nature of injury.....  
 24. Was disease or injury in any way related to occupation of deceased? Yes  
 If so, specify.....  
 (Signed) Veruman W. Meyer, M. D.  
 (Address) 5087 Grand

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

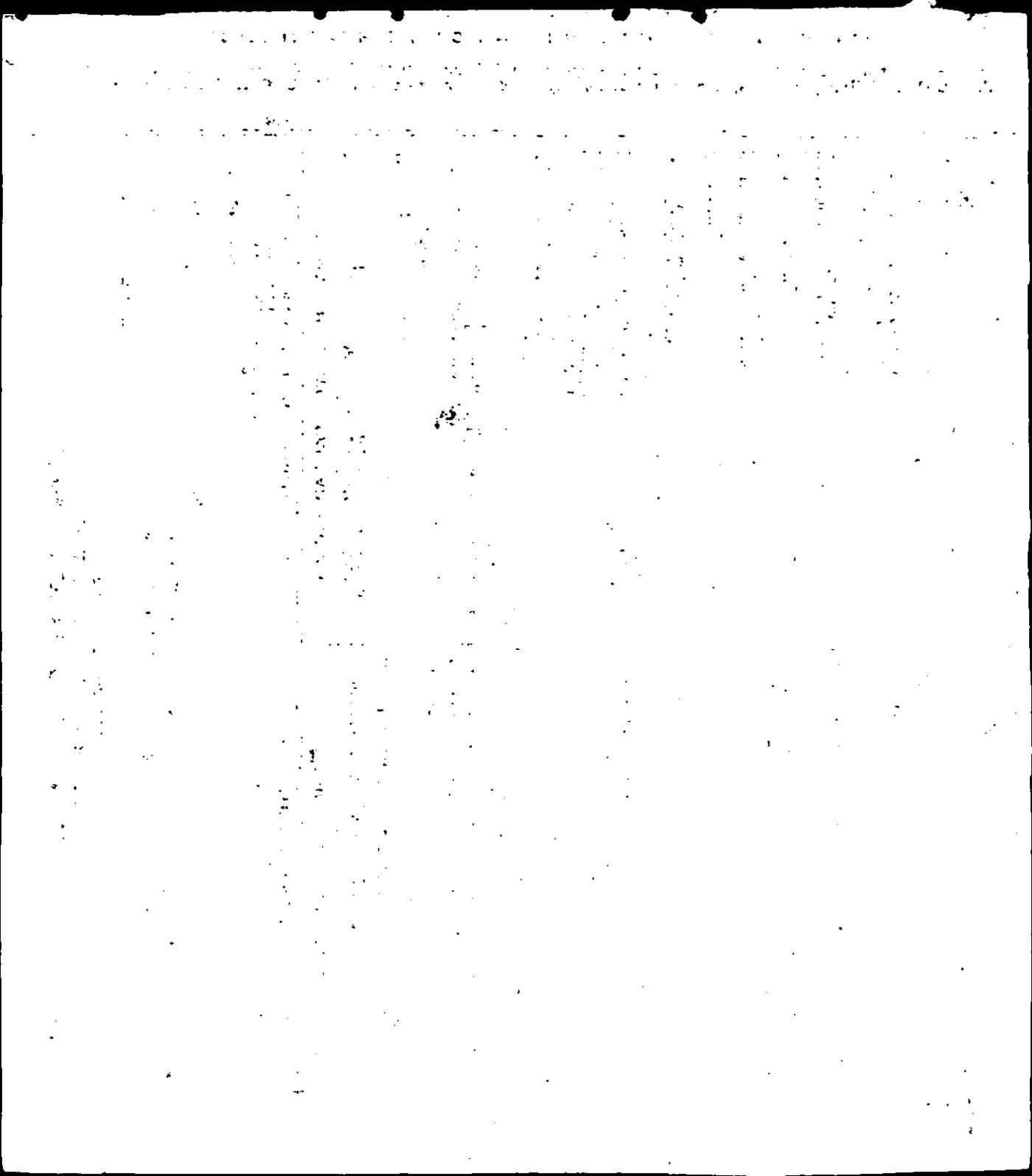
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 15 1934

MARGIN RESERVED FOR BINDING

V.S. 10-2-33 1004-11-24-33

Registrar.



#2

DEPARTMENT OF COMMERCE

E. T. McLaugh, M. D.,

BUREAU OF THE CENSUS

Special Agent,

Jefferson City, Mo.

6672

*St. Louis.*

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Manuel Rosenthal  
Who died at \_\_\_\_\_ on July - 5 - 1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex M Color or race W Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: \_\_\_\_\_

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

(Signature of Registrar J. J. Brebeck 8-29-34)

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 491 Very truly yours,

Primary Reg. Dist. No. 1003

*E. T. McLaugh, M.D.*  
Special Agent.

26504