

SEP 14 1939 **791**  
Registration District No. **1008**

Primary Registration District No. \_\_\_\_\_ Registrar's No. **7022**

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
In this community 19 years  
years, months or days

8. (a) PRINT FULL NAME Shaw Weiner 560  
3. (b) If veteran, name war None 3. (c) Social Security No. unk

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Eva Weiner 6. (c) Age of husband or wife if alive unk years  
7. Birth date of deceased Ab. 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
ab. 63 hr. min.

9. Birthplace Bessarabia Roumania  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Retail dry goods

MOTHER FATHER  
12. Name Moses Weiner  
13. Birthplace Roumania  
(City, town, or county) (State or foreign country)  
14. Maiden name Shirra Schreibman  
15. Birthplace Roumania  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harry Weiner  
(b) Address 4152a Lafayette

17. (a) Burial (b) Date thereof 8 13 39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director H. B. Berger  
(b) Address 4715 McPherson

19. (a) Aug 13 1939 (b) J. J. [Signature]  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4152a Lafayette  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.: 19 years years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 8 day 12  
year 39 hour 2:30 minute 0 P. M.  
21. I hereby certify that I attended the deceased from 8-11  
1939, to 8-12- 1939  
that I last saw him alive on 8-12- 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death intestinal obstruction  
Due to acute diarrhea and obstruction  
Due to acute diarrhea  
secondary obstruction  
Other conditions chronic beriberi  
(Include pregnancy within 6 months of death)

PHYSICIAN  
Major findings: perforated intestine with large amt. of feces - in abdomen.  
Of operations none  
Of autopsy none  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature L. F. McFarley (M. D. or other) \_\_\_\_\_  
Address 1931-8-9 3A Date signed 8-12-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. **1597**.....

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, above space should be left blank.**