

WHITE PAPER - 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.

SEP 14 1939 791  
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH: 1003

(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: 5102 Maple Ave.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County \_\_\_\_\_

(b) City or town St. Louis 5  
(If outside city or town limits, write "RURAL")

(c) Street No. 5102 Maple  
(If rural, give location)

(d) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Simon Goldberg H. 31

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Rose Goldberg 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased not known  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31 sh.  
year 1939 hour 7:30 minute A. M.

21. I hereby certify that I attended the deceased from August 8th, 1939 to August 31st, 1939

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Tailor

that I last saw him live on August 30th, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis Duration 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown Goldberg T  
13. Birthplace Russia T  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name \_\_\_\_\_  
15. Birthplace Russia  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Julia Goldberg  
(b) Address 1439 Rowan

17. (a) Burial (b) Date thereof Sept. 1-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director H. Rindskopf  
(b) Address 5216 Delmas

19. (a) AUG 31 1939 (b) J. D. Brubaker  
(Date received local registrar) (Registrar's signature)

Major findings: None

Of autopsy None made

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 J. D. Brubaker (M. D. or other) \_\_\_\_\_  
Address 5251 Walnut St. Date signed 9/31/39

*No embalming. C.F.*

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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.....

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.**