

WHILE I AM LIVE I 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34076

State File No. _____

Registration District No. 1003

Primary Registration District No. _____

Registrar's No. 8614

1. PLACE OF DEATH:
(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 28 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")
(d) Street No. 1326 Clara
(If rural, give location)
(e) If foreign born, how long in U. S. A. 28 years.

3. (a) PRINT FULL NAME Alter Shanker 526
(b) If veteran, name war no
(c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 10 day 8
year 39 hour 6 minute 25 P. M.
21. I hereby certify that I attended the deceased from 10-8, 1939, to 10-8, 1939;

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Chana Shanker
6. (c) Age of husband or wife if alive (UNK) years
7. Birth date of deceased (unk)
(Month) (Day) (Year)

that I last saw him alive on 10-8, 1939, and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Hemorrhage
Duration _____

8. AGE: Years ab. 66 Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to Arteriosclerosis
Malnutrition

9. Birthplace Volhynia U.S.S.R.
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Mohel 7

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

Major findings: Of operations _____

MOTHER FATHER { 12. Name Simcha Shanker 7
13. Birthplace U.S.S.R.
(City, town, or county) (State or foreign country)

Of autopsy no

{ 14. Maiden name (unk)
15. Birthplace U.S.S.R.
(City, town, or county) (State or foreign country)

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Julius Horwitz
(b) Address 6637 San Bonita

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) burial (b) Date thereof 10/9/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation ChasedShelEmeth

(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? _____

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

While at work? no (Specify type of place) (e) Means of injury _____

19. (a) OCT 9 1939 (b) J. Schneider
(Date received local registrar) (Signature)

23. Signature Sam Schneider (M. D. or other) _____
Address 216 S. Kingshighway Date signed 10-7-39

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.