

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.

Registration District No. _____ Primary Registration District No. _____

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 26 yrs.
years, months or days 6.25

3. (a) PRINT FULL NAME Abraham. Turken

3. (b) If veteran, name war no
3. (c) Social Security No. none

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

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 68 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Jump Dealer

11. Industry or business _____

12. Name Lakesh Turken

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

14. Maiden name Esther
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Mary Turken
(b) Address 1420 Temple St.

17. (a) burial (b) Date thereof Dec. 31-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cherish Kadasha

18. (a) Signature of funeral director W. Handley
(b) Address 4469 Washington

19. (a) DEC 31 1939 (b) J. B. Orndick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 1
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")
(d) Street No. 1420 Temple
(If rural, give location)
(e) If foreign born, how long in U. S. A. Russia (17) years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29.
year 1939. hour 8: minute 35 P. M.

21. I hereby certify that I attended the deceased from 11-29-39
_____, 19____, to 12-29, 1939.
that I last saw h. l. m. alive on 12-29, 1939.
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchopneumonia 4 days
2 Streptococcus aureus septicaemia

Due to (Post-operative)

Due to 137

Other conditions Benign hypertrophy of prostate 2 yrs.
(Include pregnancy within 3 months of death)

Major findings: Benign hypertrophy of prostate gland.
Of operations _____
Of autopsy pit. lobe.

Duration
PHYSICIAN
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 _____

28. Signature Sam Elner (M. D. Seaber)
Address 216 S. Kingshighway Date signed 12/31/39

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.....

Myself
.....
working under my personal supervision.

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

Signed *W. Z. Penhault*
.....

Licensed Embalmer No. *3669*
.....

P. O. Address *4469 Washington*
.....

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.