

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. 791 Primary Registration District No. 1000

1. PLACE OF DEATH: 1000
 (a) County St. Louis
 (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 Hospital
 (If not in hospital or institution, write street number or location) 1
 (d) Length of stay: In hospital or institution 12 days
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Isadore Peckman
 (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 62 years
 7. Birth date of deceased Sept. 5-1885
 (Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name not known
 13. Birthplace Russia
 (City, town, or county) (State or foreign country)
 14. Maiden name not known
 15. Birthplace Russia
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Isadore Peckman
 (b) Address 914 Eastgate

17. (a) Burial (b) Date thereof 1-22-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director H. Rindoff
 (b) Address 5216 Delmar

19. (a) JAN 22 1940 (b) _____
 (Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL") 7
 (d) Street No. 4824 Anderson
 (If rural, give location) _____
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 20
 year 40 hour 11 minute 30 A. M.
 21. I hereby certify that I attended the deceased from 1-8
 _____, 1940, to 1-20, 1940;
 that I last saw him alive on 1-20, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Coronary artery disease
Pericarditis?
 Due to _____
 Due to _____
 Other conditions Acute Sinusitis
 (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy no.
 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 _____

23. Signature Sam Schneider (M. D. or other) _____
 Address 214 S. Kingshighway Date signed 1-20-40

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..... *E. W. Cooper*
Licensed Embalmer No. *3830*
P. O. Address *5216 Delmar*

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.