

No. 2  
-1-4-41  
5-17-39  
I X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26191**

Registration District No. **784 1160**

Primary Registration District No. **7-15 4470**

Registrar's No. **1535**

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town University City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 710 Limit  
Registered Alien (If rural, give location)  
#1363880  
(e) Citizen or foreign country? Yes (Yes or No)  
If yes, name country U.S.S.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24  
year 1941 hour 2 minute 9 M.  
21. I hereby certify that I attended the deceased from Sept 10  
1940 to July 24, 1941  
that I last saw him alive on July 23, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Carcinoma of Lung  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Duration  
10 mo.  
PHYSICIAN  
Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

Major findings:  
Of operations.....  
Of autopsy.....

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 Harold Schuff (M. D. or other) C  
Address 703 University City Date signed 7/24/41

3. (a) PRINT FULL NAME

Harry Aronoff

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Sonia Aronoff  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased Oct. 15, 1874  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 9 9 hr. min.

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

10. Usual occupation Mgr

11. Industry or business Embroidery

12. Name Meyer Aronoff

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

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

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

16. (a) Informant Meyer Aronoff

(b) Address 7629 Wydown

17. (a) burial (b) Date thereof 7/25/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson

19. (a) JUL 24 1941 (Date received local registrar)  
H. Meyer (Registrar's signature)  
7/25/41 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

926

JUL 28 1941

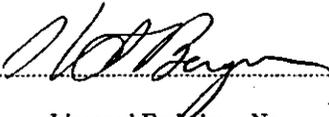
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**STATEMENT BY LICENSED EMBALMER**

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, fact should be so stated above.**