

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JUN 30 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5616

1. PLACE OF DEATH:

(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:  
Jewish Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 5182 Kensington  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME San Aronson

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 Anna Aronson

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19  
year 1943 hour 4 minute 50 P.M.

21. I hereby certify that I attended the deceased from June 17, 1943, to June 19, 1943, that I last saw him alive on June 19, 1943, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

ab. 63 hr. \_\_\_\_\_ min.

Immediate cause of death Gastric carcinoma Remission by etiology?

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

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

Other conditions Coronary artery disease  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Teacher-Piano, retired

11. Industry or business 1933

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Shachna Aronson

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

14. Maiden name Rachel Rose (unk)

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

16. (a) Informant Harry S. Sobelman

(b) Address 1395 Shawmut

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 6/19/43  
(Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emet Berger Memorial

18. (a) Signature of funeral director J. P. Bredeck

(b) Address 4715 McPherson ave

19. (a) JUN 20 1943 (b) J. P. Bredeck  
(Date received local registration) (Registrar's signature)

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 Joseph Stemberger M. D. or other \_\_\_\_\_  
Address Jewish Hosp. Date signed June 19

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

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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. 1597

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.**