

V. S. No. 2  
100M-2.43  
Revised 5-17-39  
X35897

27092

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

ED AUG 23 1943  
Registration District No. 218

Primary Registration District No. 1003

Registrar's No. 7337

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 Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 96  
(c) City or town Clayton (If outside city or town limits, write "RURAL") 2NR  
(d) Street No. 6248 Rosebury (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Celia Solomon  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug. day 14  
year 1943 hour 7 minute 20 P. M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced, Widow  
6. (b) Name of husband or wife Nathan Solomon  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 1 - 1943  
1943 to Aug 14 1943  
that I last saw her alive on Aug 14 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
about 73 -- -- hr. min.

Immediate cause of death  
Cerebral Haemorrhage (Haemorrhage)  
trauma

9. Birthplace Russia  
(City, town, or county) (State or foreign country)  
10. Usual occupation at home

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name unknown  
13. Birthplace Russia  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace Russia  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Isador Solomon  
(b) Address 6665 Washington

(Specify type of place) \_\_\_\_\_  
(Specify means of injury) \_\_\_\_\_

17. (a) Burial (b) Date thereof 8-15-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Beth Hamedreth Hagoda

Signature \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

18. (a) Signature of funeral director Herman Gindler  
(b) Address 5216 Delmar  
19. (a) AUG 15 1943 (b) J. J. Anderson  
(Date received local registrar) (Registrar's signature)

844 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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 *Chas. W. Cooper*

Licensed Embalmer No. *38370*

P. O. Address *5-216 Helmer*

**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.**