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DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
OCT 19 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32409**
Registrar's No. **8925**

Registration District No. **319**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 Days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 000
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1616 Franklin
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Joe Berger

MEDICAL CERTIFICATION

3. (b) If veteran, name war 100
3. (c) Social Security No. 495163407

20. DATE OF DEATH: Month October day 8,
year 1943 hour 9:40 minute A. M.

4. Sex MALE **5. Color of race** white
6. (a) Single, widowed, married, divorced single

21. I hereby certify that I attended the deceased from September 10, 1943, to October 8, 1943
that I last saw him alive on October 8, 1943
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

Immediate cause of death Acute cystitis with abscess formation
Duration 2 wks.

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to 137

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

Other conditions Hypertrophy of prostate -
(Include pregnancy within 3 months of death)

10. Usual occupation WAITER

Major findings: Hypertrophy of prostate -
Of operations _____

11. Industry or business _____

Of autopsy Cystitis with abscess formation, Gonorrhoeal Cystic

12. Name JACOB BERGER
13. Birthplace _____ (City, town, or county) _____ (State or foreign country) RUSSIA

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

14. Maiden name Leah
15. Birthplace _____ (City, town, or county) _____ (State or foreign country) RUSSIA

16. (a) Informant Emil Schoenfeld
(b) Address McKinley Hotel

17. (a) BURIAL (b) Date thereof 10-10-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Chevrak Radisha

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? _____

18. (a) Signature of funeral director Order handler
(b) Address 4464 Washington
19. (a) Oct 9 1943 **(b) J. F. Bredenk**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature L.T. Ford (M. D. or other) MD
Address 1515 Lafayette Avenue, **Date signed** 10/8/43

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. 369 _____

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.