

S. No. 2
M-5-43
7-5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36351

State File No. _____

FILED NOV 30 1944
318

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 9794

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: 5573 Vernon ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
12 years / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County MO 125

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

(d) Street No. 5573 Vernon ave.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Arthur Rones

3. (b) If veteran, name war no

3. (c) Social Security No. 357-09-5826

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Eunice Rotman Rones

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

7. Birth date of deceased December 6, 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>48</u>	<u>11</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation fruits & vegetables

11. Industry or business whsle & retail

12. Name Samuel Rones

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

14. Maiden name Lean Rosenblum

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

16. (a) Informant David Rones

(b) Address 5573 Vernon ave.

17. (a) burial (b) Date thereof 11/19/44
(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 ave.

19. (a) NOV 19 1944 (b) J. F. Braddock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17
year 1944 hour 4:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from 6/16/43 1943 to November 17 1944
that I last saw him alive on November 17 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Angina pectoris Duration ± 9 yrs.

Due to 61

Other conditions Diabetes Mellitus ± 1 yr
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy none

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 0

23. Signature Arthur E. Strain (M. D. or other) _____

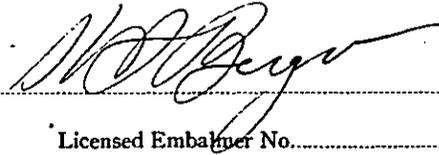
Address 539 N. Gard Date signed 11/18/44

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

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.