

Registration District No. 318

Primary Registration District No. 1005

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 5102 Northland av.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 35 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Harry Zimbler  
3. (b) If veteran, name war no  
3. (c) Social Security No. 495-14-9656

4. Sex male  
5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Bertha Zimbler  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased unknown

8. AGE: Years about 78  
Months  
Days  
If less than one day hr. min.

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

10. Usual occupation tailor

11. Industry or business

12. Name Jacob Zimbler

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

14. Maiden name Rachel (unk)

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

16. (a) Informant Mollie Zimbler

(b) Address 5102 Northland

17. (a) removal (b) Date thereof 1/22/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chicago Ills.

18. (a) Signature of funeral director Berger Memorial  
(b) Address 4715 McPherson ave.

19. (a) (Date received local registrar) (b) (Registrar's signature)

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. 5102 Northland (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21  
year 1945 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from 1935, to January 21, 1945  
that I last saw him alive on January 21, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage  
Duration: 4 days

Due to: Hypertension

Due to: Cardiovascular disease  
9/2 4 years

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: Hypertrophy of prostate  
Of autopsy: none  
PHYSICIAN: Underline the cause to which death should be charged statistically.

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?

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

23. Signature: Harvey A. [Signature] (M. D. or other)  
Address: 607 N. Grand St. Date signed: 1-21-45

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

MOTHER FATHER

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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.**