

No. 2  
1-7-43  
5-17-39  
X 35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18581

FILED JUN 19 1945

318

Primary Registration District No.

1005

State File No.

Registrar's No.

4950

Registration District No.

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:  
2709 a Shenadoah Av.  
(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)

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. 2709a Shenadoah ave.  
(If rural, give location)  
(e) Citizen of foreign country? no.  
If yes, name country.....

3. (a) PRINT FULL NAME Samuel G. Bresler.

3. (b) If veteran, name war No 3. (c) Social Security No. 493.05.4750

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
7. Birth date of deceased UNKNOWN About 1883

8. AGE: Years Months Days If less than one day  
About 61 Unknown hr. min.

9. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Maintenance Engineer

11. Industry or business.....  
12. Name Edward Bressler  
13. Birthplace Unknown West. Va.  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Ristig  
15. Birthplace Unknown Missouri!  
(City, town, or county) (State or foreign country)

16. (a) Informant Cecilia Bresler  
(b) Address 2709 a Shenadoah Av.  
17. (a) Burial (b) Date thereof 6/5/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New S. S. Peter & Paul

18. (a) Signature of funeral director Wm. E. Powell  
(b) Address 1926 Allen Av. J. F. Bredeh  
19. (a) JUN 4 1945  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2  
year 1945 hour 2 minute 45 P. M.  
21. I hereby certify that I attended the deceased from May 28 to June 2 1945  
that I last saw him alive on 6-2-45 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Due to Chronic Myocarditis  
Arteriosclerosis  
Due to Hypertension

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations.....  
Of autopsy.....  
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)  
(e) Means of injury.....  
23. Signature J. F. Bredeh (M. D. or other) MD  
Address 3115 So Grand Date signed 6/3/45

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

FORM 2  
-M  
I  
REVENUE

**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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen

**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.**

2B  
45  
143880

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 4950

Registration District No. 318

Primary Registration District No. 1003

**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:  
 (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)

**3. (a) PRINT FULL NAME** Samuel G. Bresler

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

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

**8. AGE:** Years Months Days If less than one day  
44 6 1 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

**MOTHER, FATHER** { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... (b) County.....  
 (c) City or town..... (If outside city or town limits, write "RURAL")  
 (d) Street No..... (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month..... year 1945 hour..... minute..... M.

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

immediate cause of death.....

Due to.....

Due to.....

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

Major findings:  
 Of operations.....

Of autopsy.....

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

**SUPPLEMENTARY**

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

18581