V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31524

Registration District No. 317 Primary Registration District No. 2002 Registrar's No. 2369

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6266 Enright
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town University City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6266 Enright 5
(If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ben Solomon
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lillie Solomon
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
about 66			hr. min.

9. Birthplace Brest Litovsk (City, town, or county) Poland 4 (State or foreign country)
10. Usual occupation Retail shoes
11. Industry or business
FATHER
12. Name Simon Solomon
13. Birthplace (City, town, or county) Poland 4 (State or foreign country)
MOTHER
14. Maiden name Sarah Godbetter
15. Birthplace (City, town, or county) Poland 4 (State or foreign country)
16. (a) Informant Mrs. Lillie Solomon
(b) Address 6266 Enright
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10-11-45 (Month) (Day) (Year)
(c) Place: burial or cremation Hevre Kedisha
18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 McPherson Avenue
19. (a) 10-11-45 (Date received local registrar) (b) E G McGavran M D (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9
year 1945 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from Feb. 4, 1945, to Oct 9, 1945;
that I last saw him alive on Oct 9, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: carcinomatosis	6 mo.
Due to: carcinoma of sigmoid 46	1 year.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 Joseph Magidson (M. D. or other) MD
Address 528 Wisogate Date signed 10-9-45

(Licensed Embalmer's Statement on Reverse Side)

707

Dr Magidson
570 Westgate

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.