

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 29 1945
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **35935**
Registrar's No. **9968**

Registration District No. _____ Primary Registration District No. _____

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: Jewish Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 55 years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Benjamin Tobias
3. (b) If veteran, name war no 3. (c) Social Security No. NO

4. Sex male 0 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lillian Tobias 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years about 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Poland 4
(City, town, or county) (State or foreign country)

10. Usual occupation dealer

11. Industry or business shoe repair supplies

MOTHER FATHER { 12. Name unknown
13. Birthplace Poland 4
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace Poland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Tobias
(b) Address 751 Interdrive U. City

17. (a) burial (b) Date thereof 11/18/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bnai Amoona

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

19. (c) NOV 19 1945 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1602 S. Compton (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 16
year 1945 hour 12 minute 00 A.M.
21. I hereby certify that I attended the deceased from July
1, 1945, to Nov 15, 1945;
that I last saw him alive on Nov 15, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 1 wk
Due to Cerebral Prothrombotic (Toxic + Septic)
Due to Primary site Pharynx
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy as above

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 Alvin McPherson (M. D. or other) _____
Address Jewish Hospital Date signed 11/16/45

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. 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.