

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34908
Registrar's No. 9183

FILED NOV 7 1946 18

1003

Registration District No. 6 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:
CITY HOSPITAL - NO 1 - 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 HOURS
45 YEARS (Specify whether years, months or days)

In this community 45 YEARS
years, months or days)

3. (a) PRINT FULL NAME SALEM G AZAR

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife SADIE AZAR

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

7. Birth date of deceased. ABOUT 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>ABOUT 78</u>				hr. min.

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

10. Usual occupation RETIRED

11. Industry or business GROCCER

12. Name GEORGE AZAR

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

14. Maiden name TAMMENE NESSER

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

16. (a) Informant ALBERT AZAR

(b) Address 4247 BOTANICAL AVE

17. (a) BURIAL (b) Date thereof. OCT 29/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Thoroldis & Son

(b) Address 2906 GRAYSON AVE

19. (a) OCT 28 1946 (b) J. T. Bredeck
(Date received local Registrar) (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. 4247 BOTANICAL AVE 9
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27
year 1946 hour 5:55 minute A M.

21. I hereby certify that I attended the deceased from....., 19..... 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.....
Chronic Myocarditis
Coronary
Atherosclerotic Degeneration

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 9 months of death)

Major findings:
Of operations.....

Of autopsy.....

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 Frank G Taylor (M. D. or other).....

Address St Louis Date signed 10/28/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 *Leo Budde*.....

Licensed Embalmer No. *3989*.....

P. O. Address *St Louis mo.*.....

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.