

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42969**
Registrar's No. **10309**

FILED DEC 17 1946

318

Primary Registration District No.

1003

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: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 wks. (Specify whether years, months or days)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Dr. Abraham Simon
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 Rose Simon 6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years 56 Months -- Days -- If less than one day hr. min.

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

10. Usual occupation Retired Teacher

11. Industry or business _____
12. Name Mordecai Simon
13. Birthplace Lithuania (City, town, or county) (State or foreign country)
14. Maiden name Goldie Edel
15. Birthplace Lithuania (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Simon
(b) Address 5535a Cabanne Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-1946 (Month) (Day) (Year)
(c) Place: burial or cremation Beth Hamedrosh Hagodol

18. (a) Signature of funeral director Heriman Kunder
(b) Address 3216 Delmar Blvd.

19. (c) DEC 3 1946 (Date of local registrar) J. F. Bredetz (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 5535a Cabanne Ave. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 2 year 1946 hour 4 minute 25 P.M.

21. I hereby certify that I attended the deceased from NOV 1, 1946 to DEC 2, 1946 that I last saw him alive on DEC 2, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death CANCER OF STOMACH Duration MONTHS

Due to H6

Other conditions TUBERCULOSIS OF LUNGS (Include pregnancy within 3 months of death) YEARS.

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 Dr. S. Traublin (M. D. certifying) _____
Address 634 W. Grand Date signed 12/2/46

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..... *H. E. Burgess*
Licensed Embalmer No. *4029*
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.