

No. 2
-12-45
5-17-39
I X47870

FILED FEB 17 1947

Registration District No. 317

Primary Registration District No. 3063

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

1. PLACE OF DEATH:

(a) County ST. LOUIS COUNTY

(b) City or town CLAYTON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST. LOUIS COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 DAYS 16
(Specify whether years, months or days)

In this community 25 YEARS
(Specify whether years, months or days)

3. (a) PRINT FULL NAME ROBERT NATHAN

3. (b) If veteran, name war _____ No. _____

3. (c) Social Security No. _____

4. Sex 2 MALE 5. Color or race Colored

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

6. (b) Name of husband or wife ADELINE

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased 8 29 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

64 5 2 _____ hr. _____ min.

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation JANITOR

11. Industry or business _____

MOTHER FATHER

12. Name JOHN NATHAN

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

14. Maiden name UNKNOWN

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

16. (a) Informant ADELINE NATHAN

(b) Address ROBERTS AVE., ELMWOOD

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

(c) Place: burial or cremation Greenwood Sem.

18. (a) Signature of funeral director G. H. Burke

(b) Address 212 Carroll

19. (a) 2-5-47 (b) W. H. Allen MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis County

(c) City or town ELMWOOD PARK
(If outside city or town limits, write "RURAL")

(d) Street No. ROBERTS AVENUE
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 21
year 1947 hour 5 minute 05 A. M.

21. I hereby certify that I attended the deceased from JANUARY
24, 1947, to JANUARY 31, 1947
that I last saw him alive on JANUARY 31, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure

Due to arteriosclerotic C.V. disease
& atherosclerosis

Due to 93d

Other conditions 93d
(Include pregnancy within 3 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 injury) _____
(Specify type of injury) _____

23. Signature W. H. Allen (M. D. or other) _____
Address St. Louis County Hospital Date signed 1/31/47

96

0

0

(Yes or No)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Herndon J Vandell

Licensed Embalmer No.....

4243

P. O. Address.....

*927 N. Elm St.
Hickory Grove*

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.