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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10707**  
Registrar's No. **2384**

FILED APR 14 1947 318

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **St. Louis, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **St. Louis city hospital**  
**Max C. Starkloff Memorial**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

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. **5256 Vernon Ave.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **SAM CRYSTAL**

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 **Sarah Crystal** 6. (c) Age of husband or wife if alive **57** years  
7. Birth date of deceased **Unknown**  
(Month) (Day) (Year)

8. AGE: Years **about 57** Months **--** Days **--** If less than one day hr. min.

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

10. Usual occupation **unknown**

11. Industry or business \_\_\_\_\_

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Jos. Becker**

(b) Address **5256 Vernon**

17. (a) **Burial** (b) Date thereof **3-30-1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Beth Hamedrosh Hagoda**

18. (a) Signature of funeral director **Herman Rudolph**  
(b) Address **5216 Delmar Blvd**

19. (a) **MAR 30 1947** (b) **J. F. Braddock**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **29**  
year **1947** hour **5:20** minute **A** M.

21. I hereby certify that I attended the deceased from **March 21**, 19**47**, to **March 29**, 19**47**  
that I last saw him alive on **March 29**, 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic pyelonephritis - non-calculous**  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to **1550**  
**122**

Other conditions: \_\_\_\_\_  
(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 place)  
(e) Means of injury \_\_\_\_\_

23. Signature **W. M. Fitzgibbon** (M. D. or other) \_\_\_\_\_  
Address **1515 Lafayette Avenue** Date signed **3/29/47**

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

MOTHER FATHER

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**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. 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 2384

Registration District No. 318

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: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Sam Crystal

3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color of race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased unk  
(Month) (Day) (Year)

8. AGE: act 57 Years Months Day If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business unknown

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 194 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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 place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1944 APR 10

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