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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 27 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 6076

Registrar's No. 1025

1. PLACE OF DEATH: *St. Louis*

(a) County *St. Louis*

(b) City or town *Rural: Airport Township*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **JEWISH SANATORIUM**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *2 years 10 months*  
(Specify whether years, months or days)

In this community *40 years*  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *St. Louis*

(c) City or town *St. Louis*  
(If outside city or town limits, write "RURAL")

(d) Street No. *5378 Wells*  
(If rural, give location)

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

3. (a) PRINT FULL NAME *He Weitzman*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* day *19*  
year *1947* hour *9* minute *30* P. M.

4. Sex *Male* 5. Color *White* 6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *Ester Weitzman* 6. (c) Age of husband or wife if alive *70* years

7. Birth date of deceased *unknown*  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *July 16*, 19*44*, to *May 19*, 19*47*, that I last saw him alive on *May 19*, 19*47*, and that death occurred on the date and hour stated above. Immediate cause of death *Cerebral thrombosis*

8. AGE: Years *70* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to *Generalized and cerebral arterio-sclerosis*

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

Other conditions *83k*  
(Include pregnancy within 3 months of death)

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

10. Usual occupation *Presser*

11. Industry or business *Ladies*

12. Name *Mayer Dub Weitzman*

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

14. Maiden name *Mindel*

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

16. (a) Informant *Ester Weitzman*  
(b) Address *5378 Wells*

17. (a) *Burial* (b) Date thereof *5-20-47*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Cherokh Kadisha*

18. (a) Signature of funeral director *Openhandler*  
(b) Address *5010 E. Front*

19. (a) *3-22-47* (b) *Carol A. Shapiro*  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury *D*

23. Signature *Alva Suore* (M. D. or other) \_\_\_\_\_  
Address **JEWISH SANATORIUM** signed *5-19-47*

Duration *3 1/2 years*

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.....

.....  
working under my personal supervision.

..... Registered Apprentice No.....

Signed

*J. B. Kenchard*

..... Licensed Embalmer No. *3669*.....

..... 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.**