

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1634

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 2247 Jules St.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2247 Jules St. ✓		2239	

3. NAME OF DECEASED (Type or Print) a. (First) Angelo b. (Middle) c. (Last) Ersh			4. DATE OF DEATH (Month) (Day) (Year) 2-- 19-- '55		
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5. SEX Male <input type="radio"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married ✓	8. DATE OF BIRTH July 4, 1885	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker	11. BIRTHPLACE (State or foreign country) Yugoslavia &	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Sophia Ersh
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME Sophia Ersh-2247 Jules St.,	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Indefinite Many years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Heavy work DUE TO (c) Bilateral Tubercular Pneumonia		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4222
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22. I hereby certify that I attended the deceased from January 16 1955, to Feb 21 1955, that I last saw the deceased alive on Feb 19-55, 1955, and that death occurred at 2 A.M., from the causes and on the date stated above.

23a. SIGNATURE C. G. H. Smith M.D.	(Degree or title)	23b. ADDRESS 2278 S. Jefferson	23c. DATE SIGNED 2-21-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2--22-'55	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem	24d. LOCATION (City, town or county), (State) St. Louis County, Mo
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DATE REC'D BY LOCAL REG. FEB 21 1955	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home-1926v Allen Ave	ADDRESS
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M. J. B. (Licensed Embalmer's Statement on Reverse Side)

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

2278 S. Jefferson

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Reinhold K. Lehmann

Licensed Embalmer No. 3395

P. O. Address St Louis 4 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.