

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1903**
City **St. Louis** **Essoult City Hospital**

File No. _____
Registered No. **1333**
St. _____ Ward _____

2. FULL NAME

Joseph Friedman
(a) Residence No. **2955 Dickson** St. **21** Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Rosa Friedman**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 20 - 1878**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. ____ min.
48 2 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **junk dealer**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Russia**
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER **Morris Friedman**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Russia**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Not known**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Russia**
(STATE OR COUNTRY)

14. INFORMANT **Rosa Friedman**
(Address) **2935 Dickson St.**

15. FILED **9-9-1927** **Max B. Starker**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb 8 1927**

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at **1:30 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy (Non-Fraccuscular)
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **W.M.A.**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **7401**
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE **Feb 8 1927**

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **R. S. ...**, M. D.
Feb. 9, 1927 (Address) **Canaan**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Chapel Shel Imeth Cem** DATE OF BURIAL **Feb. 9 - 1927**

20. UNDERTAKER **A. Rindskopf** ADDRESS **5216 Delmar**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No.
Township..... Primary Registration District No. 1003 Registered No. 1382
City St. Louis (No.) St. Ward (.....)

2. FULL NAME

Joseph Friedman
(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, <u>hrs.</u> or <u>min.</u>
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8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED..... 19. Mar 6 Starvo Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 7 1927

17. I HEREBY CERTIFY, That I attended deceased from

to, 19....., and that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

..... (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

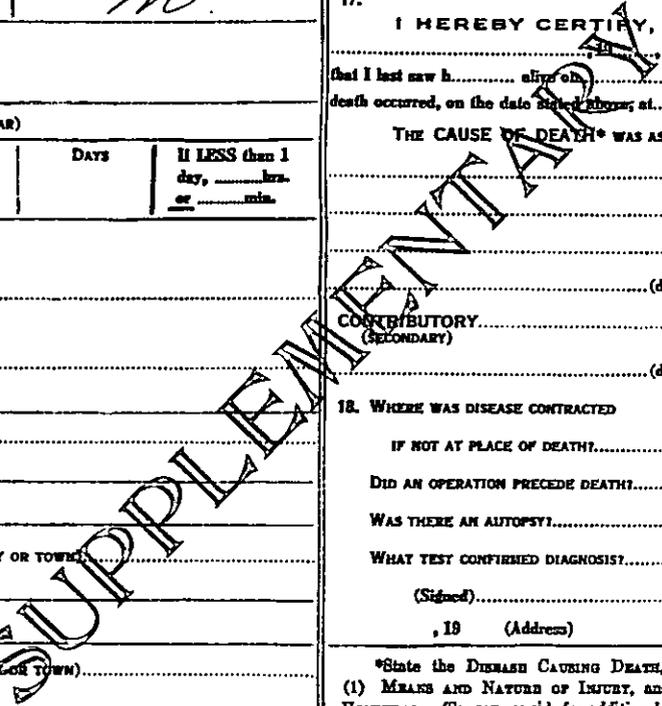
19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

Feb. 9 1927

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ver.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED



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