WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

22865

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 6534

City St. Louis (No. 1307 Washington St. ..... Ward)

2. FULL NAME Abe Soldofsky

(a) Residence. No. 6233 Wagner Pl. St., 25 Ward. St. Louis Co. Mo.
(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: Tillie Soldofsky

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb. 12 - 1892

7. AGE: YEARS 35 | MONTHS 5 | DAYS 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Resturant
(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): Chicago Ill

PARENTS

10. NAME OF FATHER: Morris Soldofsky
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Russia
12. MAIDEN NAME OF MOTHER: Beckie Becker
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Russia

14. INFORMANT: Max Soldofsky
(Address) 5747 Easton Ave.

15. FILED JUL 18 1927, 19..... Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-17-27 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 11 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Injuries
Internal
fall down elevator
shaft (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Accident
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Wm Dever M. D.
7/18/27 (Address) Dep Coroner

*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: Chesed Shel Emeth Cem.
DATE OF BURIAL: 7-18-1927

20. UNDERTAKER: H. Rindskopf
ADDRESS: 5216 Delmar