

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

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~~14-14~~

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **4003**
City St. Louis (No. 1412, Wash)

File No. **15181**
Registered No. **4106**
St. _____ Ward _____

2. FULL NAME Aaron Newman

(a) Residence. No. _____ St., 55 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, WIDOWER, OR DIVORCED HUSBAND OF (OR) WIFE OF Bertha Newman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

7. AGE YEARS 75 MONTHS _____ DAYS _____ IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Israel Newman

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

12. MAIDEN NAME OF MOTHER Leah Kuddelatai

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

14. INFORMANT Bertha Newman
(Address) 1412 Wash St.

15. APR 14 1928 New C Storking
FILED _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 13 - 1928

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1928, to 4-13, 1928
that I last saw him alive on April 12, 1928, and that death occurred, on the date stated above, at 12 Noon a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

CONTRIBUTORY (SECONDARY) 93L
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED no

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? Physical exam
(Signed) J. H. Kapelovitz, M. D.
, 19 _____ (Address) 1000 Bldg

*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 April 13 1928

20. UNDERTAKER H. Rindskoff ADDRESS 5116 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.

THIS IS A PERMANENT RECORD

100-100000

100-100000

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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..... File No.....
Township..... Primary Registration District No..... Registered No. 4106
City..... (No.....)..... St..... Ward.....

2. FULL NAME

Aron Newman

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word).....
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF.....
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Not known*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 59
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... (duration)..... yrs. mos. ds.
(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).....
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 *Bertie Newman*
(Address) *14 1/2 Wash St.*
15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 13 1928*
17. I HEREBY CERTIFY That I attended deceased from....., 19.....
(that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (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?.....
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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL..... 19.....
20. UNDERTAKER..... ADDRESS.....

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

SUPPLEMENTARY

S-19/9/5