

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

Do not use this space.

35368

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St Louis Mo** (No. **Fourth Ward**)

File No. _____
Registered No. **10111** (Ward)

2. FULL NAME

Abraham Rosenthal
(a) Residence No. **7045 Pershing** St. **12** Ward. **St Louis Mo 9A**
(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 **married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 18 / 1890**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
59 **8** **24**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Editor**
(b) General nature of industry, business, or establishment in which employed (or employer) **Editor Modern View**
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **St Louis** (STATE OR COUNTRY) **Mo**

10. NAME OF FATHER **Arum Rosenthal**

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

12. MAIDEN NAME OF MOTHER **Laura Bogel**

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

14. INFORMANT **Mrs Ida Rosenthal** (Address) **7045 Pershing**

15. FILED **Oct 15 1929** **Max C. Taylor** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10/12 - 1929**

17. I HEREBY CERTIFY, That I attended deceased from **3:22 pm 9/23**, 1929, to **10/12**, 1929, that I last saw him alive on **5:32 pm 10/12**, 1929, and that death occurred, on the date stated above, at **6 pm 10/12/29 m**

137 THE CAUSE OF DEATH* WAS AS FOLLOWS:
95% infarct of lung cause unknown
11% dilatation of heart

CONTRIBUTORY **Hypertrophy of prostate** (SECONDARY) **General** (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **9/26/29**
WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **John A. Raich**, M.D.
10/14, 1929 (Address) **Residence Fourth Ward**

*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 **Valhalla crematory** DATE OF BURIAL **10-15 1929**

20. UNDERTAKER **Wagon** ADDRESS **4316 - In dell**

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.

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