

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

7095

1. PLACE OF DEATH

County.....
Township.....
City St. Louis

Registration District No. 791
Primary Registration District No. 1703
(No. Jewish Hospital)

File No.....
Registered No. 1378
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 6118 Gambleton St. 5 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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4, 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
31 | 6 | 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Musician
(b) General nature of industry, business, or establishment in which employed (or employer). 262
(c) Name of employer

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

10. NAME OF FATHER Abelons Friedman

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

12. MAIDEN NAME OF MOTHER Dina Stillman

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

14. INFORMANT David S. Friedman
(Address) 5653 Leakes

15. FEB - 3 1931 FILED W. S. Stroh REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 2, 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to February 2nd, 1931 that I last saw him alive on February 2nd, 1931, and that death occurred, on the date stated above, at 1:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis
Hypertension
131
930 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Chronic myocarditis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

131
930
102
NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? (1)

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. Belwasser, M. D.
2/2, 1931 (Address) Jewish Hospital

*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 Beth Shalom Hag. DATE OF BURIAL 2/3 1931

20. UNDERTAKER H. B. Berger ADDRESS 4715 McPherson

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.

