

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

Do not use this space.

30043

**1. PLACE OF DEATH**

County ..... Registration District No. 100E  
Township ..... Primary Registration District No. ....  
City Saint Louis <sup>No.</sup> City Hospital

File No. ....  
Registered No. 9108  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. 4715 Verner St. Ward. .... (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
about 60-

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  Rabbi  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

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

MOTHER FATHER  
13. NAME Sam Flom

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Hospital Information Dept. City Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Chapel Hill DATE Aug 27 1931

19. UNDERTAKER (ADDRESS) O'Brien & Sons 4822 State St. St. Louis

20. FILED 21 1931 Max Standen Registrar.

**2. MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 27 1931

22. I HEREBY CERTIFY That I attended deceased from Aug 20th 31 to Aug 27th 31

I last saw him alive on Aug 27 31, 1931. Death is said to have occurred on the date stated above, at 12:50 A.M.

The principal cause of death and related causes of importance were as follows:

chronic myocarditis Date of onset  
930  
122 B  
Other contributory causes of importance:  
chronic intestinal obstruction

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify J. M. Macintosh, M. D.  
(Signed) City Hospital  
(Address)

Cause of obstruction in  
maricus from not determined  
from history. No autopsy. Sinner.

**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....  
 Township.....  
 City..... (No. ....) St. .... Ward.....  
 Registration District No. 791  
 Primary Registration District No. 1003  
 File No. ....  
 Registered No. 9108

**2. FULL NAME** Marcus Flom

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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, hrs. or min.

**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)

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 OCT 16 1931 Ray C. Standen REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 1931

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

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Chronic myocarditis  
Chronic Intestinal Obstruction  
 (duration) yrs. mos. ds.  
 CONTRIBUTOR (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

20. UNDERTAKER ADDRESS

AW  
 UNTIL THEY ARE COMPLETE AS PRESCRIBED  
 WILL NOT RECEIVE A FEE FOR CERTIFICATE

**SUPPLEMENTARY**

*Handwritten initials/signature*