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.

REC'D MAR 13 1939

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

3

791

4770
Do not use this space.

1. PLACE OF DEATH

(a) County ..... 2 Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 1463

(c) City St Louis (d) Street No. XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX St.

En route City Hospital No. 1 (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 150 Norman Rubin

(a) Residence, No. ~~St Louis Mo.~~ St. NR Boston Mass

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single 2

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 2

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 27 1907

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
31	7	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Garage Manager

9. Industry or business in which work was done, as 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) St Louis Mo 0

FATHER

13. NAME Frank Rubin 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois 6

MOTHER

15. MAIDEN NAME Emma Vogel

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

17. INFORMANT (ADDRESS) Mrs M. Smith 421 Hulls Pl.

18. BURIAL, CREMATION, OR REMOVAL

PLACE New Bethlehem Cem DATE Feb 14, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Beiderwieden Funl Home Inc 1936 St Louis Ave

20. FILED FEB 15 1939 J F Bredick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 12 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at 11:AM m.

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

Date of onset

Gun Shot Wound of right side of head self inflicted, in Room 315 Majestic Hotel, 11th & Pine Streets, February 12,1939, at about 11:00 o'clock A.M. SUICIDE.

Other contributory causes of importance:

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? Suicide Date of injury 2/12, 1939

Where did injury occur? St. Louis, Mo. (Specify city or town, county, and State)

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

Manner of injury see above

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Joseph M. Lucian, ~~M.D.~~

(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Felix J. Krupa

Licensed Embalmer No. 3497

P. O. Address 1936 St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.