

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.

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

17319  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 791  
(b) Township ..... Primary Registration District No. 1003  
(c) City or St. Louis (d) Street No. Jewish Hospital St.  
(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

Ferdinand Fischlowitz  
(a) Residence, No. 5637 Pershing St. 5  
(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 <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF <u>Emma Fischlowitz</u> (or) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>Apr. 21 1876</b>		
7. AGE <b>63</b>	YEARS <b>63</b>	MONTHS <b>1</b>
	DAYS <b>6</b>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Retired</b>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <b>Neckwear Mfg.</b>	
	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) <b>Poland</b>		
FATHER	13. NAME <b>Beryl Fischlowitz</b>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Poland</b>	
MOTHER	15. MAIDEN NAME <b>Not Known</b>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Poland</b>	
17. INFORMANT <b>Bernard Fischlowitz</b> (ADDRESS) <b>7022 Delmar</b>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Mt. Olive (Jewish)</b> DATE <b>May 29, 1939</b>		
19. FUNERAL DIRECTOR (NAME) <b>Herman Rindskopf</b> (ADDRESS) <b>5216 Delmar</b>		
20. FILE NO. <b>MAY 29 1939</b> <i>J. P. ...</i>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5/27 1939**

22. I HEREBY CERTIFY, That I attended deceased from **Nov 1928**, to **May 27 1939**  
I last saw him alive on **May 27 1939** Death is said to have occurred on the date stated above, at **11:00 p.m.**  
The principal cause of death and related causes of importance were as follows:  
**Coronary Occlusion**  
Date of onset **May 11/39**

Other contributory causes of importance:  
**Cerebral Embolism** **5/15/39**

Name of operation ..... Date of .....  
What test confirmed diagnosis? **Clinical** 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? **No**  
If so, specify .....  
(Signed) **Arthur E. Steadman** M. D.  
(Address) **532 N. Grand Ave**

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**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.....

*Chas. W. Cooper*

Licensed Embalmer No. 383 *Q*

P. O. Address.....

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

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