

REGISTRATION DISTRICT NO. **791**  
1008

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ENROUTE CITY HOSP 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community UNK  
years, months or days

8. (a) PRINT FULL NAME SAM FEIGIN 250  
9. (b) If veteran, name war UNK 3. (c) Social Security No. UNK

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced UNK

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If \_\_\_\_\_ years

7. Birth date of deceased MARCH 27 1987  
(Month) (Day) (Year)

8. AGE: Years 52 Months 3 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace DIVINSK U.S.S.R.  
(City, town, or county) (State or foreign country)

10. Usual occupation UNK

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name EPHRAIM FEIGIN

13. Birthplace U.S.S.R.  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name RACHEL LUNKI

15. Birthplace U.S.S.R.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature MRS. GUSSIE LARGER

(b) Address 48 VAN BUREN, BROOKLYN N.Y.

17. (a) BURIAL (b) Date thereof 7-25-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation B'NAL AMOONA

18. (a) Signature of funeral director H. B. BERGER

(b) Address 4715 MC PHERSON

19. (a) JUL 24 1939 (b) J. J. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State St. Louis Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis Mo. (If outside city or town limits, write "RURAL")  
(d) Street No. 107 W 6th St 25  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? unknown years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29  
year 1939 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Strangulation due to hanging by electric cord from beam on ceiling in his room at the Grand Hotel, 107 W 6th St. June 29 1939 about 3:45 PM  
Duration \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence June 29 1939

(c) Where did injury occur? St Louis Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work \_\_\_\_\_ (Specify type of place) (a) Manner of injury hanging

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address Deputy Coroner Date signed 7/15/39

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

---

---

**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.....

Licensed Embalmer No.....

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.**