

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 21 1939  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30261

REGD SEP 7 1939  
Registration District No. 1939

Primary Registration District No. 115

Registrar's No. 1488

1. PLACE OF DEATH: 2  
(a) County St. Louis  
(b) City or town University City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
902 N. 63rd  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 45 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town University City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 902 N. 63rd  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 45 years.

3. (a) PRINT FULL NAME George Stern 365  
(b) If veteran, name war no  
(c) Social Security No. 494-03-9308

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August 19 day 19  
year 1939 hour 6 minute A M.

4. Sex male  
5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Hannah Stern  
6. (c) Age of husband or wife if alive unk years  
7. Birth date of deceased (unk)  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
ab 45 hr. min.

Immediate cause of death  
Cerebral hemorrhage 1 day

9. Birthplace (unk) Poland  
(City, town, or county) (State or foreign country)

Due to Hypertension  
Due to SGA

10. Usual occupation Salesman  
11. Industry or business Movie Film 7

Other conditions (Include pregnancy within 3 months of death)  
PHYSICIAN

MOTHER FATHER { 12. Name Max Stern  
18. Birthplace Poland  
(City, town, or county) (State or foreign country)  
14. Maiden name Sophie Vittert  
15. Birthplace Poland  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Joseph Stern  
(b) Address 902 N. 63rd  
17. (a) burial (b) Date thereof 8/21/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify).  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(c) Place: burial or cremation Beth Ham Hag  
18. (a) Signature of funeral director H. B. Berger  
(b) Address 4715 McPherson  
19. (a) AUG 21 1939 (Date received local registrar)  
(b) Remy (Registrar's signature)

While at work (Specify type of place) (c) Means of injury  
28. Signature John O'Connell (M. D. or other)  
Address Coroner of St. Louis County, Mo.

**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.....

**H. I. BERGER**

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No.....

1597

P. O. Address.....

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

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