

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.

Registration District No. 1003

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Children's Hosp. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 Hrs.
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town University City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 751 Syracuse
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Michelson, Bernard

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced child
6. (b) Name of husband or wife child 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 10-20-39
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 11 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business child

MOTHER FATHER
12. Name Dan
13. Birthplace New York
(City, town, or county) (State or foreign country)
14. Maiden name Selma Cohen
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arledder
(b) Address 416 S. Kingshighway
17. (a) Burial (b) Date thereof 10-31-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place of burial or cremation CHEVRA KADISHA

18. (a) Signature of funeral director Norman K... ..
(b) Address 5216 Delmar Blvd
19. (a) OCT 31 1939 (b) J. F. Bucke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 31
year 39 hour 5 minute 5 A.M.
21. I hereby certify that I attended the deceased from 10-30
1939 to 10-31, 1939

that I last saw him alive on 10-31, 1939

and that death occurred on the date and hour stated above.
Immediate cause of death Malnutrition
dehydration & acidosis

Due to Vomiting & diarrhea
(Non-specific)

Other conditions 119
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? _____

While at work _____ (Specify type of place) (b) Means of injury _____
28. Signature R. A. Blatter (M. D. or other)
Address 608 S. Campbell Ave. Date signed _____

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 Charles Cooper
Licensed Embalmer No. 3830
P. O. Address 5216 Delma

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.