

WHILE 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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

NOV 13 1939

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34809
Registrar's No. 9347

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis Mo.

(c) Name of hospital or institution: 5563 Pershing Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Simon Landau 520

3. (b) If veteran, name war _____

3. (c) Social Security No. 488-12-3863

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Hattie E. Rosenberg

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased March 1, 1859
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>7</u>	<u>29</u>	_____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business Paper (Commercial)

12. Name Meyer Landau

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hattie Landau

(b) Address 5563 Pershing Ave

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director J. Mayer

(b) Address 4356 Lindell

19. (a) OCT 31 1939
(Date received local registrar)

J. F. Bedich
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis Mo. 12
(If outside city or town limits, write "RURAL")

(d) Street No. 5563 Pershing Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30
year 1939 hour 11 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from April 1939
_____, 1939 to Oct. 30, 1939;
that I last saw him alive on Oct. 30, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decomposition

Due to Arteriosclerotic hypertension
heart disease

Due to _____

Other conditions _____
(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) (e) Means of injury _____

23. Signature Julius Elson (M. D. or other) _____

Address 4500 Olive Date signed 10/31/39

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..... *Guy W. Wilkerson*
Licensed Embalmer No..... *3575*
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.