

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8721**
Registrar's No. **2204**

Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hospital ✓
(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 Martin Schimmel
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 24, 1922
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
17 3 10 hr. _____ min.

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

10. Usual occupation Student

11. Industry or business _____
MOTHER FATHER { 12. Name Otto Schimmel
13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Frances Feldman
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Otto Schimmel
(b) Address 3867 Shaw Ave

17. (a) Burial (b) Date thereof 3/5/1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director H.B. Berger
(b) Address 4715 McPherson Ave.

19. (a) MAR 5 1940
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3867 Shaw Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 4th
year 1940 hour 9:50 pm minute _____ M.

21. I hereby certify that I attended the deceased from Feb 23rd 1940 to March 4 1940
that I last saw him alive on March 4th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Non epidemic
meningitis about 4th
Brain abscess 11 11

Due to non epidemic meningitis - blood
spinal fluid, sputum
urine

Other conditions lung abscess 11 11
(Include pregnancy within 3 months of death)

Major findings: Brain & lung abscesses
Of operations cause unknown
Of autopsy no autopsy

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) no
(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 John T. Flynn (M. D., or other)
Address 1705 N. 29th Date signed 3-5-40

STATEMENT BY LICENSED EMBALMER

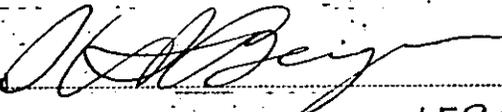
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

H. I. BERGER

Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No. 1597

P. O. Address. 4715 Mc PHERSON

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.