

FILED APR 8 1940
Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **663**

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

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Rural St. Ferdinand
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Jewish Sanatorium of St. Louis 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 20 days
(Specify whether)

In this community 1 mo. 20 days
years, months or days

3. (a) PRINT FULL NAME: ISADORE LOITERSTEIN

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: Married

6. (b) Name of husband or wife: IDA LOITERSTEIN

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

7. Birth date of deceased: AB 1896
(Month) (Day) (Year)

8. AGE: Years AB. 54 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace: U.S.S.R. 7
(City, town, or county) (State or foreign country)

10. Usual occupation: PRESSER

11. Industry or business: LADIES GARMENTS

12. Name: SOLOMON LOITERSTEIN

13. Birthplace: U.S.S.R. 7
(City, town, or county) (State or foreign country)

14. Maiden name: FANNIE (UNK)

15. Birthplace: U.S.S.R. 7
(City, town, or county) (State or foreign country)

16. (a) Informant: SARA LOITERSTEIN

(b) Address: 1437 W CLARA

17. (a) BURIAL (b) Date thereof: 4/5/1940
(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

19. (a) APR - 4 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: _____

(c) City or town: ST. LOUIS
(If outside city or town limit, write "RURAL")

(d) Street No.: 1439 CLARA AVE
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4
year 1940 hour 7 minute 35 a.m.

21. I hereby certify that I attended the deceased from February 15
1940, to April 4, 1940;
that I last saw him alive on April 4, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary thrombosis -
General arterio-sclerosis -
Angina pectoris.

Due to: _____
Due to: _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 946
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? 707

While at work? _____ (Specify type of place)
(e) Means of injury: _____

23. Signature: [Signature] (M. D. or other) MD

Address: PO ROBERTSON, MO. 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.....

NOT EMBALMED

....., 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.