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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16532

JUN 15 1940

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4010

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

1. PLACE OF DEATH:

(a) County St. Louis  
(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 50 Yrs. years, months or days)

8. (a) PRINT FULL NAME Boris Pruss 620

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Beckye Pruss 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Sept. 9 1863  
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business Artist

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Jean Pruss

(b) Address 5523 Cabanne Ave.

17. (a) Burial (b) Date thereof 5-5-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Olive Cemetery

18. (a) Signature of funeral director Heiman Rindler

(b) Address 53 16 Delmar Blvd.

19. (a) MAY 4 1940 (b) J. F. Beckie  
(Date received local health officer's signature) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5523 Cabanne Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 55 yrs. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Jan. 2 1936 to May 3 1940  
that I last saw him alive on May 2 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 3 days

Due to \_\_\_\_\_

Due to lymphosarcoma 4 yrs.  
Other conditions General Arteriosclerosis 10 yrs.  
(Include pregnancy within 5 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Broncho-pneumonia  
lymphosarcoma

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? \_\_\_\_\_

23. Signature Jean Brantberg (M.D. or other) MD

Address 3720 Washington Date signed 5-3-40

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**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 W. 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. *165-32*  
Registrar's No. *4010*

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. *791*

Primary Registration District No. *1003*

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

**1. PLACE OF DEATH:**

(a) County *St Louis*

(b) City or town *St Louis*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(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** *Boris Prusa*

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 *m*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE:	Years	Months	Days	If less than one day
	<i>76</i>	<i>7</i>	<i>24</i>	hr. _____ min. _____

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) *12-10-40* (b) *J.F. Bredeck*  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

**19. MEDICAL CERTIFICATION**

20. DATE OF DEATH Month *May* day *3*  
year *1940* hour *7* minute *05* M.

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

Due to \_\_\_\_\_ *57*

Due to \_\_\_\_\_ *57*

Other conditions \_\_\_\_\_  
(Include pregnancy within 6 months of death)  
*Mediastinal lymph nodes*  
Major findings *Broncho Pneumonia*  
Of autopsy *Lympho Sarcoma*

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) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Registration District No. 2203-57

Primary Registration District No. ....

Registrar's No. 4010

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

Boris Press

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 M

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE: Years \_\_\_\_\_

Months \_\_\_\_\_

Days \_\_\_\_\_

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_

(b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12-11-40

(b) J. P. Oreck

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 3 - 1940  
year \_\_\_\_\_ hour 7 minute 25 M.

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.

Immediate cause of death: Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: Lymphosarcoma 4 yrs  
(Include pregnancy within 3 months of death)  
Sen. arteriosclerosis

Major findings: st. cervical lymph node primary  
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 Leon Bramberg (M. D. or other) \_\_\_\_\_

Address 3772 Wash Date signed \_\_\_\_\_

SUPPLEMENTARY

USE UNFADING BLACK INK - MAKE A PERMANENT RECORD