

Registration District No. \_\_\_\_\_

791

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

4380

## 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:  
5565 Lindell Blvd  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7  
 (Specify whether  
 In this community 23 years  
 years, months or days)

3. (a) PRINT FULL NAME Theodore R. Samuels 542  
 8. (b) If veteran, name war NO 8. (c) Social Security No. 486-16-2695

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased June 11, 1916  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
23 11 5 hr. min.

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

10. Usual occupation Shoe Manfg

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

MOTHER FATHER  
 { 12. Name Theodore Samuels  
 13. Birthplace St. Louis Mo.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Rae Goodman  
 15. Birthplace Pa.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Theodore Samuels

(b) Address 5565 Lindell Blvd

17. (a) Burial (b) Date thereof 5/17/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer

(b) Address 4356 Lindell Blvd

19. (a) MAY 16 1940 (b) J. F. Braddock  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 12  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5565 Lindell Blvd  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16  
 year 1940 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from  
May 29, 1940, to May 16, 1940  
 that I last saw him alive on May 16, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Sarcoma, Malignant 1 year  
 Due to \_\_\_\_\_

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Includes pregnancy within 3 months of death) 51 D

Major findings:  
 Of operations \_\_\_\_\_  
 Of 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) \_\_\_\_\_  
 (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)  
 Means of injury \_\_\_\_\_  
 23. Signature Shirley Sale (M. D. or other)  
 Address 4500 Olive Date signed 5/16/40

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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.....

*J. G. Sullivan*

Licensed Embalmer No. 1122

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.**