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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 6 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33941

Registration District No. 791 — Primary Registration District No. 1003 — State File No. — Registrar's No. 8638

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: Enroute City Hosp. Police patrol
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis 5
(If outside city or town limits, write "RURAL")
(d) Street No. 5535 Cabanne
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Joseph H. Iskiwitch
3. (b) If veteran, name war no
3. (c) Social Security No. 489-05-6525
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sarah Iskiwithh
6. (c) Age of husband or wife if alive (unk) years
7. Birth date of deceased April 4, 1881 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
59	6	12	hr. min.

9. Birthplace West Brussia (City, town, or county) Germany (State or foreign country)
10. Usual occupation Manufacturer
11. Industry or business Work clothes
FATHER
12. Name Saul Iskiwitch
13. Birthplace West Prussia (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Anna (unk)
15. Birthplace West Prussia (City, town, or county) Germany (State or foreign country)
16. (a) Informant Mrs. Sarah Iskiwitch
(b) Address 5535 Cabanne
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/20/40 (Month) (Day) (Year)
(c) Place: burial or cremation Bnai Amoona
18. (a) Signature of funeral director H.B.Berger
(b) Address Oct 17-1940 4715 McPherson
19. (a) (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 16th year 1940 hour 4 minute — P.M.
21. I hereby certify that I attended the deceased from Feb, 1933 to Oct 16, 1940
that I last saw him alive on July 5, 1940
and that death occurred on the date and hour stated above.
Immediate cause of death Coronary thrombosis acute — Duration
Due to angina pectoris & Hypertension
Due to
Other conditions
(Include pregnancy within 3 months of death)
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: no
(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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Alfred Feldman (M. D. or other) md
Address 634 N Grand Date signed Oct 16/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.