

4-40
-39
23159

7-1940

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 2126

1. PLACE OF DEATH: St. Louis

(a) County St. Louis

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

(c) Name of hospital or institution 7 Crestwood Dr. - Clayton
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 38 yrs.
years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Clayton
(If outside city or town limits, write "RURAL")

7 Crestwood Dr.

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 58 yrs years.

3. (a) PRINT FULL NAME Louis Goldman

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10-40
year 10 hour 4.5 minute _____ M.

21. I hereby certify that I attended the deceased from June 26
1940, to Nov 10, 1940;

that I last saw him alive on Nov 10, 1940;
and that death occurred on the date and hour stated above.

3. (b) If veteran, name war _____ 3. (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 Pauline Goldman 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

Immediate cause of death Cerebral apoplexy

Duration Nov 3rd 1940

8. AGE: Years About 70 Months --- Days --- If less than one day _____ hr. _____ min.

Due to _____

Due to Stroke

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

10. Usual occupation Retired

11. Industry or business Tailor

MOTHER FATHER { 12. Name Unknown

13. 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)

Other conditions Stroke
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Samuel Edison

(b) Address *7 Crestwood Dr. Clayton

17. (a) Burial (b) Date thereof 11 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cem.

18. (a) Signature of funeral director H. Rindorf

(b) Address 5216 Belmont

19. (a) NOV 11 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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 A. M. Brand (M. D. or other) _____

Address 3651 Brandlitz Date signed 11/11/40

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

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 *Chas W. Cooper*

Licensed Embalmer No. *3830*

P. O. Address *5216 Delmar*

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

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