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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 25 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17021

State File No. _____
Registar's No. **4539**

Registration District No. **791**

Primary Registration District No. **1003**

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: **JEWSISH 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 **36 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **000**
(c) City or town **ST LOUIS** **617**
(If outside city or town limits, write "RURAL")
(d) Street No. **1446 CLARA** **9**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **36** years.

3. (a) PRINT FULL NAME **PHILIP RASKIN**

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 **SARAH RASKIN** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **UNKNOWN**
(Month) (Day) (Year)

8. AGE: Years **74** Months _____ Days _____ If less than one day
ADT. hr. _____ min.

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

10. Usual occupation **TAILOR**

11. Industry or business **Meds SUITS**

12. Name **Philip Raskin**

13. Birthplace **RUSSIA**
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

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

16. (a) Informant **Mrs Minnie Altman**

(b) Address **1414 Montclair**

17. (a) **Burial** (b) Date thereof **5-30-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Beth HAMADASH HXG-dol**

18. (a) Signature of funeral director **Odenhandler**

(b) Address **4469 Washington**

19. (a) **MAY 30 1941** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **29** year **1941** hour **8** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **MARCH**, 1941, to **MAY**, 1941; that I last saw him alive on **MAY 29**, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: **Cancer of stomach with metastases**

Due to: **[Signature]**

Due to: **[Signature]**

Other conditions (Include pregnancy within 3 months of death): **Ascites with edema, secondary**

Major findings: Of operations **None**

Of autopsy **NO**

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 **[Signature]** (M. D. or other) **[Signature]**
Address **10 Theatre Bldg** Date signed **5/30/41**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.....

myself
....., Registered Apprentice No.....
working under my personal supervision.

Signed *H. O. Tenhopper*
.....
Licensed Embalmer No. *3669*
.....

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, fact should be so stated above.