

Registration District No. 201

Primary Registration District No. 1003

Registrar's No.

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 \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County St. Louis  
 (c) City or town St. Louis Clayton Mo. NR  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 7452 Parkside  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Cassell  
 (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Feb., day 21  
 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced, widowed  
 (b) Name of husband or wife Saddie Cassell  
 (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: not known  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 20 1942 to Feb 20 1942  
 that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

8. AGE: Years about 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: stroke  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace: Poland  
(City, town, or county) (State or foreign country)  
 10. Usual occupation: Mechant  
 11. Industry or business: New York N.Y.

Other conditions: Hypertension, left  
(Include pregnancy within 3 months of death)  
 Major findings: due to a cerebral hemorrhage  
 Of operations: following hypertension  
 Of autopsy \_\_\_\_\_

MOTHER FATHER

12. Name: Abraham Cassell  
 13. Birthplace: Poland  
(City, town, or county) (State or foreign country)  
 14. Maiden name: Rebecca Roudemsky  
 15. Birthplace: Poland  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant: Mrs Sam E. Grodsky  
 (b) Address: 7452 Parkside  
 17. (a) Burial (b) Date thereof: 2-23-42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation: Beth Hamedrosh Hagodai  
 18. (a) Signature of funeral director: A Rindskopf  
 (b) Address: 6216 Belmont  
 19. (a) FEB 22 1942 (b) J. F. Medeck  
(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. J. ... (M. D. or other) \_\_\_\_\_  
 Address: 636 N. ... Date signed: Feb 22

**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.....

*C. 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 comply with the above constitutes grounds for revocation of license.)**

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