

FILED APR 13 1942 791

Registration District No.

Primary Registration District No. 1003

Registrar's No. 2842

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 4 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County NR
(c) City or town Decatur
(If outside city or town limits, write "RURAL")
(d) Street No. Alien (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1942 hour 1 minute 15 PM

21. I hereby certify that I attended the deceased from March 28 1942 to March 30 1942
that I last saw h.e.v. alive on March 30 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Failure Duration

Due to Unknown as to

Due to sep. dis of heart

Other conditions Pneumonia, Bron
(Include pregnancy within 3 months of death)

Major findings:
Of operations none 10/7
Of autopsy none 10/1
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) (e) Means of injury _____

23. Signature Joseph Stolar (M. D. or other) _____
Address 508 N. Grand Date signed 3/30/42

3. (a) PRINT FULL NAME Rose Ticker Tick

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex femaale 5. Color or race White 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Sol Tick 6. (c) Age of husband or wife if alive (unk) years

7. Birth date of deceased Jan 10 1899
(Month) (Day) (Year)

8. AGE: Years 43 Months 2 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Prostken E Prussia Germany
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Herman Simberg

13. Birthplace Prostken Germany
(City, town, or county) (State or foreign country)

14. Maiden name Holdine Abraham

15. Birthplace E. Prussia Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Sol Tick

(b) Address Decatur Ill

17. (a) burial (b) Date thereof 3/31/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Decatur Ill

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson

19. (a) MAP (b) J F Bredbeck
(Date received local registrar) (Registrar's signature)

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

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MOTHER FATHER

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 with the above constitutes grounds for revocation of license.)

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