

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 22 1947 91

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 5038

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:
1370 Montclair
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 months
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME ISADORE SEIGAL

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

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

6. (b) Name of husband or wife Fannie Seigal 6. (c) Age of husband or wife if alive 53 years

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

8. AGE:	Years	Months	Days	If less than one day
	<u>Abt. 63</u>			hr. _____ min.

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

10. Usual occupation Shoe Maker
Shoe Repair

11. Industry or business Beril Seigal

12. Name Beril Seigal
 13. Birthplace Russia
 (City, town, or county) (State or foreign country)

14. Maiden name Chave
 15. Birthplace Russia
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joe Seigal
 (b) Address 5846a Maffit

17. (a) Burial (b) Date thereof 6 10 42
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Open handler
 (b) Address 4469 Washington

19. (a) JUN 10 1947 (b) J. F. Bredeak
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1370 Montclair
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
 year 1947 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from March 6, 1947, to June 9, 1947
 that I last saw him alive on April 28, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Inoperable Bronchogenic Carcinoma (primary in the Right lower lobe)
 Due to _____
 Due to _____

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

Major findings: Removal of supraclavicular lymph
 Of operation made by Dr. Brian Platen revealed Bronchogenic Carcinoma
 Of autopsy Autopsy note obtained

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)
 (c) Means of injury _____

23. Signature David M. Scilling (M. D. or other)
 Address 4500 Olive Street Date signed 6-9-47

Duration

6 months

PHYSICIAN

Underline the cause to which death should be charged statistically

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

W. B. Kenhandler
.....
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, above space should be left blank.