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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1942
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STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 28479
Registrar's No. 8070

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(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 11
(c) City or town Madison Illinois 0NR
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME

Max Adler

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 Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 8 1873
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business Mens Wear

12. Name Ludwig Adler

13. Birthplace Bohemia

14. Maiden name Francisca Oesterreicher

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

16. (a) Informant Joseph Adler

(b) Address 5814 Pershing Ave.

17. (a) Burial (b) Date thereof 9-30-1942
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Harman Gindesberg

(b) Address 5216 Delmar Blvd.

19. (a) SEP 29 1942 (b) J. F. Bredech
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 28
year 1942 hour 5⁰⁰ minute P M.

21. I hereby certify that I attended the deceased from Sept 23 1942 to Sept 28 1942
that I last saw him alive on Sept 28 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocarditis from acute hypertrophy 1 day
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Prostatic Hypertrophy - benign
Of operations _____
Of autopsy none

Duration
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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Harry C. Oiler (M. D. or other)
Address 4500 Olive Date signed 9-29-42

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

MOTHER: FATHER:

W. W. ...

BERNARD ...

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 Helman

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28479
Registrar's No. 8070

Registration District No.

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:
Jewish Hosp
(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)

3. (a) PRINT FULL NAME Max Adler

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased Oct 8 - 1877
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days..... If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 25
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I first saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death..... Duration

Due to.....
Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
.....
(Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

