

FILED OCT 6 1942  
318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

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:  
Missouri Baptist Hosp. O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community 42 yrs  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5904 Enright  
(If rural, give location)  
(e) Citizen of foreign country?..... No (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Maxwell Tabacnic

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. single  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased December 25 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57 8 29 hr. min.

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

10. Usual occupation Physician

11. Industry or business.....

12. Name Aaron Tabacnic  
13. Birthplace Russia  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Boonshaft  
15. Birthplace Russia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dora Wohlgenuth  
(b) Address 1032 Curran

17. (a) burial (b) Date thereof 9/25/42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial  
(b) Address 4715 McPherson

19. (a) SEP 25 1942 (b) J. F. Bredeck  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24th  
year 1942 hour 1 minute 10 p.a.m.

21. I hereby certify that I attended the deceased from 9-20-42 to 9-24-42  
that I last saw him alive on 9-20-42 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Consequences (Virus Infection)  
Due to Myelitis (Disseminated)  
Due to Cause Unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....  
Of autopsy Reported

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?

While at work? (Specify type of place) (a) Means of injury 0  
23. Signature R. K. Andrews (M. D. or other)  
Address 4932 Astor Court Date signed 9-25-42

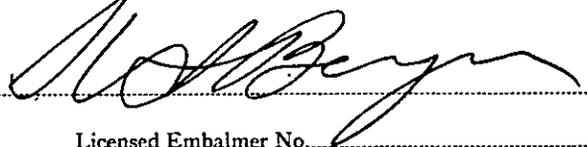
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.**

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