

S. No. 2
M-1-4-41
v. 5-17-39
X26390

35294

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 23 1942

1003

9495

Registration District No. 818

Primary Registration District No. _____

Registrar's No. _____

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: Stone's Nursing Home 437 West Pine Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether
In this community 35 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000
17
(c) City or town St. Louis (d) Street No. 1435a Blackstone
(If outside city or town limits, write "RURAL")
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME JAKE CYTRON
(b) If veteran, name war No
(c) Social Security No. 490-12-6246

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 13 day Nov
1942 year 1942 hour 1 minute 30 P. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Dora
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased Unknown abt 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan
19 1931 to Nov 13 1942
that I last saw him alive on Nov 13 1942
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
Abt. 67 br. min.

Immediate cause of death Cerebral Thrombosis Duration 3 days

9. Birthplace Russia 6
(City, town, or county) (State or foreign country)

Due to Paralysis Arteriosclerosis 54 years
Due to CA 15

10. Usual occupation Presser

Other conditions Arteriosclerosis 15 years
(Include pregnancy within 3 months of death)

11. Industry or business Men's clothes

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name Wolf Cytron
13. Birthplace Russia 6
(City, town, or county) (State or foreign country)
14. Maiden name Etta Laha
15. Birthplace Russia 6
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Etta Korman
(b) Address 7431 Cornell

17. (a) Burial (b) Date thereof 11-15-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth
(d) Signature of funeral director Openhandler

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? _____

18. (a) Address 4460 Washington
(b) NOV 14 1942 (Date received local registrar)
(c) J. F. Biedeck (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Harold Schiff D. (M. D. or other)
Address 607 N. Grand Date signed 11/13/42

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

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. Penhallow

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, fact should be so stated above.