

FILED FEB 10 1943

Registration District No. **784**

Primary Registration District No. **115**

Registrar's No. **58**

96  
533  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town University City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
8042 Delmar Blvd. /  
(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 St. Louis

(c) City or town University City  
(If outside city or town limits, write "RURAL")

(d) Street No. 8042 Delmar Blvd  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph Fishman

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8  
year 1943 hour 9 minute 35 P. M.

21. I hereby certify that I attended the deceased from now  
29 1940 to 1 / 18 1943  
that I last saw him alive on 11/8/18 1943  
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Rose Fishman 6. (c) Age of husband or wife if alive not known years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

Immediate cause of death: Coronary Occlusion

Due to: Coronary Heart Disease

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

8. AGE: Years about 64 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation: Retired

11. Industry or business: Loan Business

12. Name: Abraham Fishman

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

14. Maiden name: Sarah Kessler

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

16. (a) Informant: Mrs. Rose Fishman

(b) Address: 8042 Delmar Blvd.

17. (a) Burial (b) Date thereof: 1-11-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation B'nai Amoona

18. (a) Signature of funeral director: H. Pindskopf

(b) Address: 5216 Delmar Blvd.

19. (a) JAN 11 1943 (b) E. J. McKeown  
(Date received from Registrar) (Registrar's signature)

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)

(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: E. P. Potashnick (M. D. or other) M.D.  
Address: 401 Humboldt Bldg Date signed: 1/9/43

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

FEB 20 1947

MAR 10 1943

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**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..... *5116 Delmar*.....

**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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