

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4451

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1725

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..... 36 yrs
years, months or days)

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. 5895 Nina Pl.
(If rural, give location)
 (e) Citizen of foreign country?.....
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Abe Landes

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife..... Ida Forman Landes 6. (c) Age of husband or wife if alive..... (unk) years

7. Birth date of deceased..... November 20 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>3</u>	<u>1</u>	hr. min.

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

10. Usual occupation..... Retail grocer

11. Industry or business.....

MOTHER FATHER

12. Name..... Max Landes

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

14. Maiden name..... Anna Krasner

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

16. (a) Informant..... Mrs. Ida Landes

(b) Address..... 5895 Nina Pl.

17. (a) burial (b) Date thereof..... 2/22/43
(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) FEB 23 1943 (b) J. J. Brudick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 21st
 year 1943 hour 2 minute A.M.

21. I hereby certify that I attended the deceased from Feb. 14
1943 to Feb 21 1943;
 that I last saw him alive on Feb. 21 1943;
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
1) Cerebral Hemorrhage?
2) Cerebral Embolism
3) Cardiac decompensation
 Due to..... Postic Heart disease
Hypertension

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

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

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..... Julius Elson (M. D. or other)
 Address..... 4500 Olive St. Date signed..... 2/24/43

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..... 1597

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.