

REG. MAR 20 1943 818
Registration District No. **818**

Primary Registration District No. **1003**

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

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: **Children's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether
In this community **15 days**
years, months or days)

3. (a) PRINT FULL NAME **JACK MICHAEL HYMAN CYTRON**

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 **March 3rd 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 15 hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business _____

MOTHER FATHER { 12. Name **Hyman Cytron**
13. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Clara Lebman**
15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hyman Cytron**
(b) Address **4713a Newberry**

17. (a) **burial** (b) Date thereof **3/19/43**
(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) **MAR 19 1943** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4713a Newberry**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **18**
year **43** hour **12** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **3-17-43**
to **3-18-43**
that I last saw him alive on **3-18-43**
and that death occurred on the date and hour stated above.

Immediate cause of death
Bronchopneumonia
Capillary Bronchitis

Duration
3 days
3 days

Due to _____

Due to **107**

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

Major findings:
Of operations _____

Of autopsy **Not done**

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)
(e) Means of injury _____

23. Signature **K. J. Patton** (M. D. or other) _____
Address **107** Date signed _____

