

X32873

FILED APR 3 1943 8  
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: JEWISH HOSPITAL 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 weeks  
In this community 28 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County 000  
(c) City or town ST LOUIS 17 1/2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4641 VERNON  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MAX FELDMAN  
(b) If veteran, name war NO (c) Social Security No. 498-01-8605

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 23  
year 1943 hour 2 minute 15 P.M.

4. Sex male 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced SINGLE  
(b) Name of husband or wife \_\_\_\_\_ (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 12 1914  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 12  
1943 to March 23 1943  
that I last saw him alive on March 23 1943  
and that death occurred on the date and hour stated above.

8. AGE	Years	Months	Days	If less than one day
<u>28</u>	<u>4</u>	<u>11</u>		hr. _____ min. _____

Immediate cause of death Cardiac Insufficiency from Rheumatic Heart Disease & mitral aortic insufficiency  
Due to Rheumatic Heart Disease 12 yrs  
mitral aortic insufficiency  
Due to \_\_\_\_\_

9. Birthplace ST LOUIS MO. 0  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation AUTO

11. Industry or business Mechanic  
12. Name SAM FELDMAN  
13. Birthplace RUSSIA  
(City, town, or county) (State or foreign country)  
14. Maiden name MARY GOLDSTEIN  
15. Birthplace RUSSIA  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Sam Feldman  
(b) Address 4641 Vernon  
17. (a) BURIAL (b) Date thereof 3-26-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Chesed Shel Emet

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) Signature of funeral director Chenhandler  
(b) Address 4469 WASHINGTON  
19. (a) MAR 25 1943 (b) J. F. [Signature]  
(Date received local registrar) (Registrar's signature)

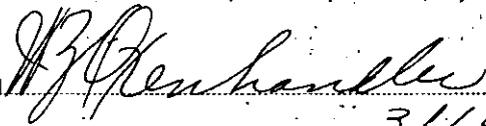
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature W. R. [Signature] (M. D. or other) MD  
Address 216 S. Knapfield Date signed 3/24/43

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



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.**