

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23430

REG. AUG 12 1943  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6962

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:  
1490 Blackstone /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... 36 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ike Roufa

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, married

6. (b) Name of husband or wife..... Ray Roufa 6. (c) Age of husband or wife if alive, unk years

7. Birth date of deceased Jan. 15 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 6 16 ..hr. ..min.

9. Birthplace Volhynia U.S.S.R. 6  
(City, town, or county) (State or foreign country)

10. Usual occupation retail grocer

11. Industry or business.....

12. Name Joseph Leib Roufa

13. Birthplace U.S.S.R. 6  
(City, town, or county) (State or foreign country)

14. Maiden name Esther Baile (unk)

15. Birthplace U.S.S.R. 6  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Albert

(b) Address 6983 Cornell

17. (a) burial (b) Date thereof August 1, 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) AUG 7 1943 (b) J. F. Busack  
(Date received local registration) (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. 1490 Blackstone  
(If rural, give location)  
(e) Citizen of foreign country? Alien # (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31  
year 1943 hour 125 minute P M.

21. I hereby certify that I attended the deceased from July 8 1943 to July 31 1943, that I last saw him alive on July 31 1943, and that death occurred on the date and hour stated above.

Immediate cause of death..... coronary thrombosis

Due to arterio sclerosis general

Due to.....

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

Major findings:  
Of operations.....

Of autopsy..... none

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 Joseph M. Madison (M. D. or other) no  
Address 5106 Calhoun Date signed 7/31/43

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

MOTHER FATHER

Duration

45 min.

many years

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....



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.**