

FILED NOV 1 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9424

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: JEWSISH HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 DAYS  
(Specify whether years, months or days)

In this community 35 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST. LOUIS

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 740 EAST GATE  
(If rural, give location)

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

3. (a) PRINT FULL NAME LOUIS SALZMAN

3. (b) If veteran, name war NO

3. (c) Social Security No. NOVE

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife SALZMAN

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased UNKNOWN  
(Month) (Day) (Year)

8. AGE: Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation DEALER

11. Industry or business SAVING

12. Name YITZCHOK SALZMAN

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

14. Maiden name LEAH

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

16. (a) Informant Bernard Salzman

(b) Address 740 East Gate

17. (a) BURIAL (b) Date thereof 10-27-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chasod Shel EMETH

18. (a) Signature of funeral director Orehandler

(b) Address 4469 Washington

19. (a) OCT 26 1943 (b) JF Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25  
year 1943 hour 8 minute 15 PM

21. I hereby certify that I attended the deceased from Oct 15, 1943, to Oct 25, 1943; that I last saw him alive on Oct 25, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Post-op shock

Due to Empyemic Aortitis

Due to Bacteri Hemipneumonia of Right L.

Other conditions 137  
(Include pregnancy within 3 months of death)

Major findings: Of operations Bacteri Hemipneumonia

Of autopsy Empyema

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 Leo O. Sacher (M.D. or other) M.D.

Address 216 S. Humphreys Date signed Oct 26 1943

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

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.**