

V. S. No. 2
FORM--2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39772

State File No.

FILED JAN 12 1944 818

Registration District No.

Primary Registration District No.

1003

Registrar's No.

11933

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: City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 day
In this community 7 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6400 Cabanne
(If rural, give location)
(e) Citizen of foreign country? alien #1 444 425 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME Morris Farber

3. (b) If veteran, name war no 3. (c) Social Security No. 465-20-6605

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

6. (b) Name of husband or wife Rose Farber 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased April 15, 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 8 14 hr. min.

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

10. Usual occupation designer

11. Industry or business ladies coats

MOTHER FATHER { 12. Name Hyman Aaron Farber
13. Birthplace U.S.S.R. 6
(City, town, or county) (State or foreign country)
14. Maiden name Jennie (unk)
15. Birthplace U.S.S.R. 6
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Farber
(b) Address 6400 Cabanne ave.

17. (a) burial (b) Date thereof 12/31/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth Berger Memorial

18. (a) Signature of funeral director 4715 McPherson ave.
(b) Address

19. (a) DEC 31 1943 (b) Jo F. Bradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29
year 1943 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. im. alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage
83
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
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) (c) Means of injury _____

23. Signature Alfred G. Perry (M.D. or other) _____
Address 6400 Cabanne Date signed 12/31/43

(Licensed Embalmer's Statement on Reverse Side)

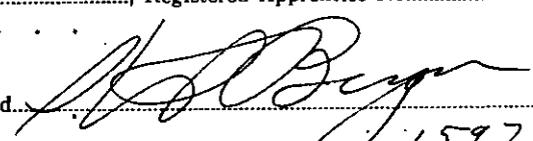
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1254

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.