

FILED FEB 28 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1472**

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: De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
in this community _____ 35 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6677 Washington
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME David Segal

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 Esther Rosenthal Segal 6. (c) Age of husband or wife if alive (unk) years
7. Birth date of deceased April 15 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 9 29 hr. min.

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

10. Usual occupation Dealer, Retail

11. Industry or business tools and machinery

12. Name Hyman Segal

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

14. Maiden name Jochnebed (unk)

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

16. (a) Informant Mrs. Esther Segal

(b) Address 6677 Washington

17. (a) burial (b) Date thereof 2/15/44
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director _____

(b) Address 4715 McPherson ave.

19. (a) FEB 15 1944 (Date received local registrar) J. F. Brink (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14 year 1944 hour 6 minute 00 A. M.

21. I hereby certify that I attended the deceased from Dec 20, 1943 to Feb. 14, 1944
that I last saw him alive on Feb. 13, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Hemorrhage Duration 4 days
Due to Hypertension + arb. arterios.

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: 83
Of operations _____
Of autopsy _____

Duration

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? _____

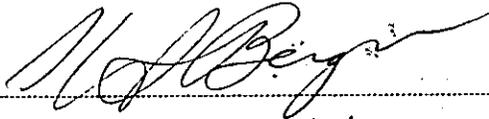
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. F. Brink (M. D. or other) MD
Address 401 Hamilton Bldg. Date signed 2/14/44

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..... 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.