

FILED APR 1 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Jewish Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 days  
(Specify whether  
 In this community ?  
years, months or days)

3. (a) PRINT

FULL NAME Joe Tenen

3. (b) If veteran,

name war ?

3. (c) Social Security

No. ?

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 11 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>7</u>	<u>13</u>	hr. _____ min. <u>6</u>

9. Birthplace Zhitomer VOLHYNIA USSR  
(City, town, or county) (State or foreign country)

10. Usual occupation junk dealer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Hospital records

(b) Address Jewish hospital

17. (a) Burial (b) Date thereof 3/28-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth Cem.

18. (a) Signature of funeral director Bergan Memorial

(b) Address 4715 McAderson ave

19. (a) MAP 28 1924 J. F. Bredak  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
17  
 (c) City or town St. Louis 921  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1800 Gale  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 28  
 year 44 hour 3 minute A M.

21. I hereby certify that I attended the deceased from 3  
21, 1944, to 3 28, 1944  
 that I last saw him alive on 3-28, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Stroke Duration 2 days

Due to Post-op  
 Due to \_\_\_\_\_

Other conditions metastatic cancer of rectum 1 year  
(include pregnancy within 3 months of death)

Major findings: 4/10 PHYSICIAN \_\_\_\_\_  
 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)  
 (e) Means of injury \_\_\_\_\_

23. Signature Leo J. Fischer (M. D. or other) MD  
 Address 216 S. Kingshighway Date signed 3-28-44

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

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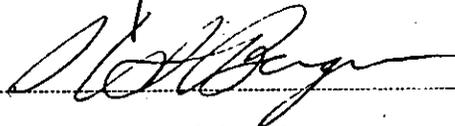
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*no embalming*

Registered Apprentice No.....

working under my personal supervision.

Signed..... 

Licensed Embalmer No.....

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.**