S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 9 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30556

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 980

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rear 7th & Sylvania (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 50 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 1065 N Noyes (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Hyman Rosenthal
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) [redacted], widowed, [redacted]
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 12 (Day) 1874 (Year)

8. AGE: Years 70 Months 2 Days 20 If less than one day hr. min.

9. Birthplace (City, town, or county) 4 Poland (State or foreign country)
10. Usual occupation Owner Hat & Cap Co.
11. Industry or business
FATHER 12. Name Un Known
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Joe Optican
(b) Address St Joseph
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-44 (Month) (Day) (Year)
(c) Place: burial or cremation Shoare Sholem
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph, Mo
19. (a) 10/4/44 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2nd year 1944 hour 4 minute P M.
21. I hereby certify that I ~~attended~~ viewed the deceased from on Oct 2, 1944, to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death: Multiple Fractures of the Skull with loss of brain Substance and fatal hemorrhage. — Duration: 1 day
Due to Fracture of left leg, right arm and left shoulder, numerous cuts and abrasions on chest and fracture of
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations several ribs
Of autopsy No.

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) Accident 131
(b) Date of occurrence Oct 2 - 1944
(c) Where did injury occur? St Joseph (City or town) Buchanan (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Industrial plant (Specify type of place)
While at work? yes (e) Means of injury Elevator
23. Signature H. F. Mundy (M. D. or other) Coroner
Address 404 So 3d St Date signed 10/2/44

1377

(Licensed Embalmer's Statement on Reverse Side)

DEC 9 1940

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 Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, Mo

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.