

FILED FEB 7 1945
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Registrar's No. 854

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County..... St. Louis
 (b) City or town.....
 (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) 10
 (d) Length of stay: In hospital or institution..... 40 years (Specify whether
 In this community..... years, months or days)

3. (a) PRINT FULL NAME Abraham Margulis

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 widower

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

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

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

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

10. Usual occupation general mdse.

11. Industry or business retired

12. Name Benjamin Margulis

13. Birthplace U.S.S.R.
 (City, town, or county) (State or foreign country)

14. Maiden name unk

15. Birthplace U.S.S.R.
 (City, town, or county) (State or foreign country)

16. (a) Informant Harry Margulis

(b) Address 5790 McPherson ave.

17. (a) burial (b) Date thereof 1/28/45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bnai Amoona

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson ave.

19. (a) JAN 28 1945 (b) J. J. Budek
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
Pine Lawn
 (c) City or town.....
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6104 St. Paul pl.
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27
 year 1945 hour 6:30 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 21
 1945 to Jan 27 1945

that I last saw him alive on Jan 26 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death.....

Gangrene of rt. leg
subcutaneous emphysema
 Due to probable tear of trachea or
bronchus (cause undetermined)

Due to.....

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

Major findings:
 Of operations.....

Of autopsy none

22. If death was due to external causes, fill in the following:

(c) 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 Alfred J. Feldman (M. D. or other) md

Address 634 IVth Street Date signed 1/27/45

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. 1097

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.