No. 2
I—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4143

Registration District No. FILED MAR 14 1945 318 Primary Registration District No. 1003 Registrar's No. 1593

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: Emmanuel City 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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 4001 Washington (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Samuel B. Dickstein

3. (b) If veteran, name war

3. (c) Social Security No. 409-09-4218

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 53 years

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

8. AGE: Years Abt. 54 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Designer

11. Industry or business Dress

FATHER
12. Name Abraham Zolomon Dickstein
13. Birthplace (City, town, or county) Russia (State or foreign country)

MOTHER
14. Maiden name Chai Sura
15. Birthplace (City, town, or county) Russia (State or foreign country)

16. (a) Informant Elenore Schrier

(b) Address 6309a Cabanne

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-45 (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Openhandler

(b) Address 4469 Washington

19. (a) FEB 19 1945 (Date received local registrar) (b) J. F. Brideck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18th year 1945 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from , 19 , 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 Carbon Monoxide Poisoning as a result of a fire in his room

Due to Caused by smoking a cigarette in bed on

Due to Feb. 18, 1945 exact time unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 178C

Of autopsy 14

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) Accident

(b) Date of occurrence Feb 18 1945

(c) Where did injury occur? St Louis Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury as above

23. Signature Alfred Perry (M.D. or other)

Address Cigarette House Date signed 2/19/45

(Licensed Embalmer's Statement on Reverse Side)

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 W. J. Fenhandler

Licensed Embalmer No. 3669

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.