

S. No. 2
 DM-5-43
 v. 5-17-39
 I X36671

FILED MAR 5 1945
 Registration District No. 597

Primary Registration District No. 6076

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Ellisville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Sunset Sanitarium
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Juda Molasky
 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 Fannie Molasky
 6. (c) Age of husband or wife if alive 3 years
 7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
about 88				hr. min.

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

10. Usual occupation retail dry goods

11. Industry or business retired

MOTHER FATHER
 12. Name Jacob Molasky
 13. Birthplace U.S.S.R.
(City, town, or county) (State or foreign country)
 14. Maiden name Rug (Ukr)
 15. Birthplace U.S.S.R.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruth Holtzman

(b) Address 753 Leland U. City

17. (a) burial (b) Date thereof 3/1/45
(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) MAR 1 1945 (b) Dr. E. G. McHannan
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town University City
(If outside city or town limits, write "RURAL")
 (d) Street No. 753 Leland
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes; name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 26
 year 1945 hour 7 minute 02 P.M.
 21. I hereby certify that I attended the deceased from 2-22-45
 1945 to 2-26-45 1945

that I last saw him alive on 2/24 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Acute cardiac dilatation</u>	<u>1 day</u>
Due to <u>Chronic myocarditis</u>	<u>no</u>
Due to <u>arteriosclerosis</u>	<u>?</u>
Other conditions <u>Chronic bronchitis</u> <small>(Include pregnancy within 3 months of death)</small> <u>Senile dementia</u>	
Major findings: Of operations <u> </u>	
Of autopsy <u>930</u>	

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 (M. D. or other) MD
 Address Kirkwood, Mo Date signed 3/1/45

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

JUN 27 1955

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..... *M. A. Berger*

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.