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Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15464**  
Registrar's No. **4479**

FILED JUN 4 1945  
**100318**

**1003**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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17  
9  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:  
1438 E. Grand  
(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 Missouri (b) County 030

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

(d) Street No. 1438 E. Grand  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Raphael Pastel

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mollie Pastel 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years About 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business Tailor

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Ferd Kantrovitz

(b) Address 5794 Kingsbury Ave.

17. (a) Burial (b) Date thereof 5-21-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director H. Rindskopf, Inc

(b) Address 15216 Delmar Blvd.

19. (a) MAY 21 1945 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1945 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from Feb. 15 1945 to May 19 1945 that I last saw him alive on May 15 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cellulitis of Back  
(Include pregnancy within 3 months of death) 2 wks

Major findings: from arteriosclerosis

Of operations none

Of autopsy \_\_\_\_\_

Duration 7 days

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 Frank Cohen (M. D. or other) \_\_\_\_\_

Address 462 No Taylor Date signed 5/20/45

**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.....

*H. E. Burgess*  
4029

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.**