V. S. No. 2
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ev. 5-17-39
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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. 18264

FILED JUN 4 1945

Registration District No. 317 — Primary Registration District No. 6076 — Registrar's No. 1040

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town Rural: St. Ferdinand Township (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: JEWISH SANATORIUM (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town University City (If outside city or town limits, write "RURAL")

(d) Street No. 6263 North Drive (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME NATHAN SHAPIRO

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 Dora Shapiro

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

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

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired

11. Industry or business Cabinet Maker

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

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

16. (a) Informant Rose Shapiro

(b) Address 6263 North Drive

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-45 (Month) (Day) (Year)

(c) Place: burial or cremation Chevra Kadisha Cem.

18. (a) Signature of funeral director Herman Rudskopf

(b) Address 5216 Delmar Blvd.

19. (a) MAY 1 1945 (Date received local registrar) (b) E. G. McCauran (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 26 year 1945 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 16, 1945, to April 26, 1945 that I last saw him alive on April 26, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Massive lung hemorrhage	10 minutes
Due to: Malignancy of Mediastinum	2 years
Due to: 47f	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Selig Simon (M. D. or other)

Address JEWISH SANATORIUM Date signed 4/26/45

(Licensed Embalmer's Statement on Reverse Side)

JUN 5 1945

JUN 17 1945

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.

JUN 8 1945

Signed.....

Licensed Embalmer No. 4029

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.