

FILED OCT 6 1945

Primary Registration District No. 1003

Registrar's No. 8474

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

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis Jewish Hospital
(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)
 In this community 41 years

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 000
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL.")
 (d) Street No. 6151 Kingsbury
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Lloyd Jacobs A COBS

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, married

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

7. Birth date of deceased April 15, 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>5</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace Brest-Litovsk Poland - 4
(City, town, or county) (State or foreign country)

10. Usual occupation retail fruits and veg.

11. Industry or business unemployed

12. Name Nehemiah Jacobowitch
 13. Birthplace Poland 4
(City, town, or county) (State or foreign country)
 14. Maiden name Miriam (unk)
 15. Birthplace Poland 11
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M. Jacobs

(b) Address 6151 Kingsbury

17. (a) burial (b) Date thereof 10-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson Avenue

19. (a) OCT 1 1945 (b) J. F. Braddock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
 year 1945 hour 11 minute 05 P. M.

21. I hereby certify that I attended the deceased from 9/26/45
 _____, 1945 to 9/29, 1945

that I last saw him alive on 9/29, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Bronchopneumonia
 Duration 10 min.
1 Day

Due to Generalized arteriosclerosis
Heart, hy. atrophy
 20.4%

Due to Pulmonary emphysema
Myocardial infarction

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

Major findings:
 Of operations _____

Of autopsy Coronary Thrombosis
Pulmonary emphysema, Bronchopneumonia

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 J. F. Braddock (M. D. or other) _____

Address 3725 Washington Date signed 9/30/45

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. 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.