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v. 5-17-39  
I X35897

31428

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 9349

FILED OCT 13 1946  
3/7

Registration District No. \_\_\_\_\_ Primary Registration District No. 2070

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Webster Groves  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Miriam Convalescent Home 4  
(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

3. (a) PRINT FULL NAME Isadoro Feingold  
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 Divorced  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years About 55 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Dress Operator

11. Industry or business Dress

12. Name Unknown

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

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

16. (a) Informant Morton Feingold

(b) Address 1975 Walton-New York, N. Y.

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation B'nai Amoona Cem.

18. (a) Signature of funeral director H. R. ...  
(b) Address 5216 Delmar Blvd.

19. (a) 10-10-45 (b) H. D. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Illinois (b) County 999  
(c) City or town Mt. Vernon  
(If outside city or town limits, write "RURAL")  
(d) Street No. 802 N. Seventh  
(If rural, give location)  
(e) Citizen of foreign country? 2 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month October day 9<sup>th</sup> year 1945 hour 5 minute A. M.  
21. I hereby certify that I attended the deceased from July, 1945, to October 9, 1945, and that I last saw him alive on October 8, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death:  
Chronic occlusion  
Arteriosclerotic Degenerative Heart Disease  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration  
1 day  
1 yr.  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 Herman M. Meyer (M. D. or other) MD  
Address 508 N. Grand Date signed 10/9/45

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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 E Burgess* .....

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.

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