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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 29 1945

State File No. 34710

Registration District No. 30

Primary Registration District No. 6676

Registrar's No. 2562

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Lemay Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Mississippi River 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~St. Louis~~ 500

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5882 Page 9
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME Leon Simon

3. (b) If veteran, name war no

3. (c) Social Security No. 492-01-1451

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Rose Lander Simon

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

7. Birth date of deceased December 29, 1899
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
45	9	25	..... hr. ..... min.

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

10. Usual occupation barber

11. Industry or business .....

FATHER
12. Name Moses Simon
13. Birthplace ..... (City, town, or county) Lithuania (State or foreign country)

MOTHER
14. Maiden name Frooma Siegel
15. Birthplace ..... (City, town, or county) Lithuania (State or foreign country)

16. (a) Informant Louis Lander
(b) Address 7445 Tulane

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (Month) (Day) (Year)
(c) Place: burial or cremation Beth Ham. Hag.

18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 McPherson ave.

19. (a) 10-26-45 (Date received local registrar) (b) E. G. McGovern M.D. (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24th
year 1945 hour Unk minute Unk M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

Immediate cause of death Drowning in Mississippi River

Due to .....

Due to Suicide 1646

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

Major findings:
Of operations .....

Of autopsy no

Duration

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) Suicide

(b) Date of occurrence Oct 4th to Oct 24, 1945

(c) Where did injury occur? St Louis Co Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Mississippi River
(Specify type of place)

While at work? no (e) Means of injury Drowning

23. Signature Arnold J. Willmann (M.D. or other)

Address ..... Date signed .....

707

(Licensed Embalmer's Statement on Reverse Side)

OCT 31 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 no embalming, Registered Apprentice No. ....., working under my personal supervision.

Signed [signature]

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.

No. 2B
-3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34710

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2562

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town (Le May, Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(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 (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Leon Simon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 29 (Day) 89 (Year)

8. AGE: Years 45 Months 9 Days 23 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec day 24
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY