

S. No. 2
 00M-5-43
 Rev. 5-17-39
 I X3667

FILED JUN 30 1946

Registration District No. _____ Primary Registration District No. **1003**

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:
923 Washington
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community **20 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County _____
 (c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5857th Ferry**
(If rural, give location)
 (e) Citizen of foreign country? _____ (or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME **Morris Levine**
 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 **SINGLE**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **JULY 1 1914**
(Month) (Day) (Year)

8. AGE: Years **31** Months **11** Days **3**
 If less than one day _____ hr. _____ min.

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

10. Usual occupation **MANUFACTURER**

11. Industry or business **HATS**

12. Name **BEN LEVINE**

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

14. Maiden name **EDITRA SIMBELMAN**

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

16. (a) Informant **Max Levine**

(b) Address **5862nd Ferry**

17. (a) **BURIAL** (b) Date thereof **6-7-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chevrah Kadisha**

18. (a) Signature of funeral director **[Signature]**

(b) Address **4469 Washington**

19. (a) **JUN 6 1946** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **June** day **4**
 year **1946** hour **11** minute **00** A.M.
 21. I hereby certify that I attended the deceased from **Dec. 1, 1944**
 to **June 4, 1946**
 that I last saw him alive on **June 4, 1946**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac failure**
 Due to **arterio stenosis**
mitral stenosis
 Due to **Rheumatic fever**
 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? **0**

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 Signature **M. Norman Orzel** (M. D. or other) **M. D.**
 Address **634 North Grand** Date signed **6/4/46**

(Licensed Embalmer's Statement on Reverse Side)

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

20824

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. G. Olenkander

Licensed Embalmer No.

3669

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.