

FILED NOV 6 1946

Registration District No. _____ Primary Registration District No. **6076**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Parish: Airport 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 **4 1/2 years**
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **Paul Mendel**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **486-14-4829**

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, 1979**
(Month) (Day) (Year)

8. AGE: Years **67** Months **3** Days **27** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Orderly - Hospital**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Dr. Selig Simon**

(b) Address **Jewish Sanatorium**

17. (a) **Burial** (b) Date thereof **10/29/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Mt. Sinai**

18. (a) Signature of funeral director **Berger Memorial**

(b) Address **4715 McPherson Avenue**

19. (a) **10-30-46** (b) **Ruth Miller MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

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

(d) Street No. **Jewish Sanatorium**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **28** year **1946** hour **12** minute **25** P.M.

21. I hereby certify that I attended the deceased from **April 23**, 19**46**, to **October 28**, 19**46**; that I last saw him alive on **October 28**, 19**46**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral thrombosis** Duration **4 days**

Due to **general arteriosclerosis** Since **many years**

Due to **and**

Other conditions **arteriosclerosis heart disease**
(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Selig Simon MD** (M. D. _____)
Address **JEWISH SANATORIUM** Date signed **10/29/46**

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4-46

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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.....

Lewis S. Ludwig

Licensed Embalmer No.

42279

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.