

No. 2
-12-45
-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6619**

APR 11 1947 318

Primary Registration District No. **10031003**

Registrar's No. **2119**

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

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jewish Hos'p
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 1 day
years, months or days)

3. (a) PRINT FULL NAME Abraham (ABE) P. Levy

3. (b) If veteran, name war none

3. (c) Social Security No. _____

4. Sex male 5. Color or race W.

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

6. (b) Name of husband or wife Lucille Frank Levy

6. (c) Age of husband or wife if alive 51 years 1878

7. Birth date of deceased August 22 (Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 9 If less than one day hr. min.

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

10. Usual occupation retired

11. Industry or business General Merchant

MOTHER FATHER { 12. Name Moses Levy

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

14. Maiden name Augusta

15. Birthplace U.S.A. (City, town, or county) (State or foreign country)

16. (a) Informant Herbert Levy

(b) Address 6312 Southwood

17. (a) Burial (b) Date thereof 3/3/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

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

(b) Address 4356 Lindell Blvd

19. (a) APR 2 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 6312 Southwood
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 1
year 1947 hour 7 minute 35 AM

21. I hereby certify that I attended the deceased from 2-27-47
1947 to 3-1-47 1947

that I last saw him alive on 3-1-47 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to cerebral arterial sclerosis

Other conditions Broncho-pneumonia, heart

Major findings:
Of operations _____
Of autopsy as above

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 A. E. Schweitzer (M. D. or other) [Signature]

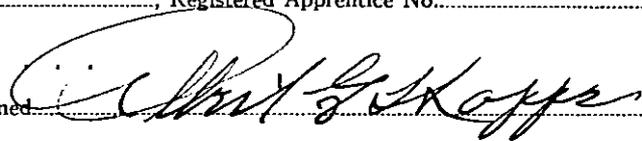
Address Jewish Hospital Date signed 2 Mar 47

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..... 2971.....

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.