

No. 2
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5-17-39
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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

15484

State File No.

FILED APR 21 1947

3763

Registrar's No.

Registration District No. 318

Primary Registration District No.

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: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community
years, months or days

3. (a) PRINT FULL NAME NEETS, MEYER.
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 Married
6. (b) Name of husband or wife Annie Neets
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 67 hr. min.

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

10. Usual occupation Tailor

11. Industry or business.....

MOTHER FATHER
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 Mrs. Meyer Neets
(b) Address 5504 Wells Ave.

17. (a) Burial (b) Date thereof 4-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Norman R. Saloff, Inc.
(b) Address 5216 Delmar Blvd.

19. (a) APR 9 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5504a Wells
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR day 8
year 1947 hour 7 minute 03 P.M.
21. I hereby certify that I attended the deceased from 7 APR
1947 to 8 APR 1947;
that I last saw him alive on 8 APR 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
① BRONCHOPNEUMONIA, BILAT.
② TRACHEAL OBSTRUCTION
Due to FROM THYROID TUMOR
③ MALNUTRITION
Due to Non-toxic tumor
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....
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).....
(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 A. E. Schechter (M. D. or other) M.D.
Address Jewish Hospital Date signed 9 Apr 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..... *H. P. 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.