

FILED SEP 15 1950

1003 State File No. 28017
Registrar's No. 7505

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2129
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital			d. STREET ADDRESS (If rural, give location) 4515 Maryland Ave.		
3. NAME OF DECEASED (Type or Print) ABE		a. (First)	b. (Middle)	c. (Last) BLOCH	4. DATE OF DEATH (Month) (Day) (Year) Sept. 2, 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 17, 1879	9. AGE (In years last birthday) 71	10. MONTHS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Furniture	11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Sady Bloch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. A. Bloch-4515 Maryland Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH 1 day 4 1/2
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 3:32 PM			
22. I hereby certify that I attended the deceased from Feb 10, 1950 , to Sept 2, 1950 , that I last saw the deceased alive on Sept 2, 1950 , and that death occurred at 5:30 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) W. M. Freund M.D.			23b. ADDRESS 1703 Grand		23c. DATE SIGNED 9/2/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/3/50	24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE SIGNED BY LOCAL REGISTRAR SEP 3 1950	REGISTRAR'S SIGNATURE J. B. Sasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman Rudolph Kofman 5216 Delmar			

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

ml

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

John Ketter
Licensed Embalmer No. *3880*

Signed.....
Student Embalmer

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.