No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28690

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7024

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis,Missouri
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St.Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 6 ST LOUIS 2069

d. STREET ADDRESS (If rural, give location): 2729 N. UNION BLVD

3. NAME OF DECEASED (Type or Print)
a. (First): HAROLD
b. (Middle):
c. (Last): SOLOMON

4. DATE OF DEATH (Month) (Day) (Year): August 17th, 1950

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: UNKNOWN-abt-39
9. AGE (In years last birthday): If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: BRUSHES
11. BIRTHPLACE (State or foreign country): ST LOUIS MO
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: ALBERT SOLOMON
13b. MOTHER'S MAIDEN NAME: FANNIE SERENCO
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: FANNIE SOLOMON 853 WESTGATE

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Amyotrophic lateral sclerosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
(1) Cystitis - (2) large decubitus ulcers

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 3561

22. *I hereby certify that I attended the deceased from* 5/27/50, 19__, *to* 8/17/50, 19__, *that I last saw the deceased alive on* 8/17/50, 19__, *and that death occurred at* 8:20pm *m., from the causes and on the date stated above.*

23a. SIGNATURE SCHIELE (Degree or title): Herbert S. Schiele, Jr MD
23b. ADDRESS: 1515 Lafayette Ave.,
23c. DATE SIGNED: 8/18/50

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 8-20-1950
24c. NAME OF CEMETERY ~~OR CREMATORY~~: CHESED SHEL EMETH
24d. LOCATION (City, town, or county) (State): ST LOUIS MO

DATE REC'D BY LOCAL REG.: AUG 18 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Herman Rindskopf 5216 DELMAR 3 Kyd

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed John Ketter

Signed.....
Student Embalmer

Licensed Embalmer No. 3880

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.