

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED SEP 24 1946

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Iron River Airport Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Special Sanatorium O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year 3 months
(Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME MORTIS LAZARUS

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 Rose Lazarus 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years About 64 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Tailor

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Rose Lazarus

(b) Address 5372 Maple

17. (a) Burial (b) Date thereof 9-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation B'nai Amoona Cem.

18. (a) Signature of funeral director H. R. Rindolph

(b) Address 5216 Delmar Blvd.

19. (a) 9-11-46 (b) Ruth J. Allen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carter
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5372 Maple 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day nine
year 1946 hour ten minute 10 P. M.

21. I hereby certify that I attended the deceased from June 10, 1945, to September 9, 1946;
that I last saw him alive on September 9, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction Duration 3 weeks
Due to hypertensive and arteriosclerotic heart disease since 9 years

Due to 93-A

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____
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) (c) Means of injury _____

23. Signature Alvin D. ... (M. D. or other) _____

Address Special Sanatorium, Bee Tree Road Date signed 9/19/46

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.....

J. E. 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.