

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 43 days
(Specify whether years, months or days)

In this community 31 years

3. (a) PRINT FULL NAME MAX RECHT

3. (b) If veteran, name war no

3. (c) Social Security No. 497-01-0705

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Sarah Recht

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

7. Birth date of deceased October 15, 1885
(Month) (Day) (Year)

8. AGE: 59 Months 2 18 20 If less than one day
hr. _____ min. _____

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

10. Usual occupation merchant

11. Industry or business auto parts etc.

12. Name Menachem Mendel Recht

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

14. Maiden name Sarah Esther (unk)

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

16. (a) Informant Henry Lacks

(b) Address 1081 Midland U. City

17. (a) burial (b) Date thereof 1/4/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson ave.

19. (a) JAN 4 1945 (b) J. F. Bredsch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 728 Pennsylvania
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 3
year 1945 hour 8 minute 5 P.M.

21. I hereby certify that I attended the deceased from Dec 24
1944 to JAN 3 1945
that I last saw him alive on JAN 3 1945
and that death occurred on the date and hour stated above.

Immediate cause of death uremia

Duration 48 hrs

Due to 107

Due to _____

Other conditions Bilateral Pneumonia - Bron
(Include pregnancy within 3 months of death)

Major findings: Subtotal gastrectomy

Of operations _____

Of autopsy none

PHYSICIAN
Underline cause of death which 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? _____

White _____ (Specify type of place)
Means of injury _____

23. Signature H. R. Butcher (M. D. or other) _____
Address Barnes Hospital Date signed 1-3-45

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

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17
9

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. 1597

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.