

FILED JUN 4 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4515**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **City Sanitarium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution **24 yrs. 10 mos. 10 ds.**
(Specify whether
In this community **35 yrs.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **088**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **4158 Walsh St.** (If rural, give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country..... **0**

3. (a) PRINT FULL NAME **ROSA EBL.**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **March 13 1863**
(Month) (Day) (Year)

8. AGE: Years **82** Months **2** Days **6** If less than one day hr. min.

9. Birthplace **unknown Hungary**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business

12. Name **Morris Greznicker**
13. Birthplace **Hungary** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Rose ? Greznicker**
15. Birthplace **Hungary** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **St. Singler**
(b) Address **5400 Arsenal St.**

17. (a) **Burial** (b) Date thereof **May 22, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Walter Feldner**
(b) Address **3634 Gravois Ave.**

19. (a) **MAY 22 1945** (b) **J. F. Bredich**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19**
year **1945** hour **10.30** minute **A** M.

21. I hereby certify that I attended the deceased from **August 1st**, 19**44** to **May 19**, 19**45**
that I last saw her alive on **May 19**, 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Due to..... **Degenerative Heart Disease** 10 yrs. x
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....
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?.....

While at work?..... (Specify type of place) (c) Means of injury **0**
23. Signature **Therese Baumer** **W. D.**
Address **5400 Arsenal** (M.D. or D.O.) **5/19/45**
Date signed

WRITE PLAINLY—USE 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Robert Wheeler
Licensed Embalmer No. 2128
P. O. Address St Louis Mo

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.