

S. No. 2
M-8-43
7. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32499

FILED NOV 2 1945
310

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State File No. _____

Registrar's No. 9100

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME LOUIS WEXLER

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race White

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

6. (b) Name of husband or wife Anna Wexler

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Abt. 54 hr. min.

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

10. Usual occupation JUNK DEALER

11. Industry or business _____

12. Name MAYER WEXLER

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

14. Maiden name ESTHER

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

16. (a) Informant William Wexler

(b) Address 5821 Thaxt

17. (a) BURIAL (b) Date thereof 10-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CHESED SHELEMETH

18. (a) Signature of funeral director Openhandly

(b) Address 4469 Washington

19. (a) OCT 22 1945 (b) J. F. Reddeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ST. LOUIS (b) County _____

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

(d) Street No. 5574 Cate Brillante
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21
year 1945 hour 11 minute 25 P. M.

21. I hereby certify that I attended the deceased from Oct. 15, 1945, to Oct. 21, 1945
that I last saw him alive on Oct. 21, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 1 day

Due to Coronary artery disease

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94

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) (e) Means of injury _____

23. Signature M. Norman Orzel (M. D. or other) M. D.

Address 634 W. Grand Date signed 10/22/45

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

17
9

6000
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.

Not Embalmed

Signed *W B Genharder*.....

Licensed Embalmer No. *3669*.....

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.