

**FILED** DEC 15 1945

Registration District No. **2**

Primary Registration District No. **3069**

Registrar's No. **2775**

1. PLACE OF DEATH

(a) County **St. Louis**  
(b) City or town **Clayton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **St. Louis County Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **26 days**  
(Specify whether years, months or days)  
In this community **15 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Louis**  
(c) City or town **Clayton St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2821 Newmark**  
(If rural, give location)  
(e) Citizen of foreign country? **No**  
If yes, name country

3. (a) PRINT FULL NAME **Wittich George A**

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 **M**  
6. (b) Name of husband or wife **Julia Licht** 6. (c) Age of husband or wife if alive **57** years  
7. Birth date of deceased **Jan 3 1875**  
(Month) (Day) (Year)

8. AGE: Years **70** Months **11** Days **2** If less than one day  
hr. min.

9. Birthplace **St. Louis** (City, town, or county) **Mo** (State or foreign country)

10. Usual occupation **none**

11. Industry or business **none**

12. Name **Henry Wittich**  
13. Birthplace **Germany** (City, town, or county) (State or foreign country)  
14. Maiden name **Velove Muske**  
15. Birthplace **Germany** (City, town, or county) (State or foreign country)

16. (a) Informant **patient**  
(b) Address **2821 Newmark**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-8-45**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **New Packer Washer-Welderle**

18. (a) Signature of funeral director **Washer-Welderle**  
(b) Address **3634 Gravois Ave**

19. (a) **12-8-45** (Date received local registrar) (b) **E. M. Garavito** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **5**  
year **1945** hour **7** minute **20** A. M.

21. I hereby certify that I attended the deceased from **11** **9** 19**45** to **12-5-45** 19**45**  
that I last saw him alive on **12/5/1945** and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized Arteriosclerosis**  
Due to **Cerebral arteriosclerosis**

Due to **97**

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) (e) Means of injury  
23. Signature **Clara Hendin** (M. D.)  
Address **601 Buntwood Cty** Date signed **12/5/45**

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

96  
2  
3

---

---

**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.....  
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.**