

No. 2
A-2-43
5-17-39
I X35637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED FEB 20 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. **8112**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1302**

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: Alexian Brothers 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3933 S. Broadway
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Abraham Wurzman

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5 year 46 hour 3:25 minute 00 P. M.

21. I hereby certify that I attended the deceased from April 7 1946 to Feb 5 1946 that I last saw him alive on 2/5/46 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased July 23, 1858
(Month) (Day) (Year)

Immediate cause of death: Chr. Myocarditis
Arteriosclerosis
Hypertension

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 9/30

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

8. AGE:

Years	Months	Days	If less than one day
<u>87</u>	<u>6</u>	<u>12</u>	_____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Don't Know

13. Birthplace Don't Know
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know

15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records
(b) Address 3933 S. Broadway

17. (a) Burial (b) Date thereof Feb. 7, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director Weick Brothers
(b) Address 2201 S. Grand Bl.

19. (a) FEB 7 1946 (b) J. F. Bredeck
(Date received by Registrar) (Registrar's signature)

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) _____
_____ (Specify type of means of injury)

23. Signature J. F. Bredeck (M. D. or other) M.D.
Address 5899 Delmar Date signed 2/6/46

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

Dr. Mayhem
No. 579 Allen
Ca 7401
~~80~~
No. 9112

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 Harry A. Stewart

Licensed Embalmer No. 3722

P. O. Address. 412 Duchouquette St.

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.