

JAN 22 1943 318  
Registration District No. ....

Primary Registration District No. .... 1003

Registrar's No. .... 424

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

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:  
Missouri Baptist 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..... (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town ..... Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7750 Kingsbury Blvd.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Samuel Horwich  
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: unmarried  
6. (b) Name of husband or wife..... Sara Horwich 6. (c) Age of husband or wife if alive. 68 years  
7. Birth date of deceased..... not known  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 14  
year 1943 hour 11 minute 25 P. M.  
21. I hereby certify that I attended the deceased from  
Jan 2, 1943, to Jan 14, 1943;  
that I last saw him alive on Jan 14, 1943;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
about 71 hr. min.

Immediate cause of death.....  
Chronic myocarditis 1 year  
Gastrointestinal tuberculosis 2 weeks  
Due to..... Arteriosclerosis general 5 years  
Central Nervous System Leses 28 years?  
Due to.....  
Other conditions..... Pituitary tumor of stalk 2 years  
(include pregnancy within 3 months of death)

9. Birthplace..... Germany  
(City, town, or county) (State or foreign country)  
10. Usual occupation..... Retired -  
11. Industry or business..... Theater Owner  
12. Name..... Unknown  
13. Birthplace..... Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name..... Unknown  
15. Birthplace..... Germany  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations.....  
Of autopsy.....

16. (a) Informant..... Marion Plessner  
(b) Address..... 7545 Cornell  
17. (a) Burial (b) Date thereof 1-15-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation..... Mt. Olive Cemetery  
18. (a) Signature of funeral director..... H. Rindskopf  
(b) Address..... 5216 Delmar  
19. (a) JAN 15 1943 (b) J. F. Bredeek  
(Date received local 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) (e) Means of injury.....  
23. Signature..... Norton J. Evered (M. D. or other) M.D.  
Address..... 4129 Washington Blvd. Date signed..... 1-15-43

MOTHER FATHER

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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 C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 5216 Delmar

**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.**