

No. 2
5-43
5-17-39
X38671

FILED DEC 9 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10519**

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether

In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County.....

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

(d) Street No. 5748 McPherson Ave
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Alexander Earle Horwitz

3. (b) If veteran, name war none 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 Dora Prinz Horwitz 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased September 25 1879
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>64</u> | <u>2</u> | <u>5</u> | hr. <u>4</u> min. |

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

10. Usual occupation Physician

11. Industry or business Dr. of ...

12. Name Robert Horwitz

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

14. Maiden name Sophie Sachs

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

16. (a) Informant Mrs Alex Wondy

(b) Address 5748 McPherson Ave

17. (a) Burial (b) Date thereof 12/2/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive (Jewish)

18. (a) Signature of funeral director Mayer

(b) Address 4356 Lindell Blvd

19. (a) NOV 30 1943 (b) J. J. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11/30 day 30
year 1943 hour 3 minute 30 a. M.

21. I hereby certify that I attended the deceased from Nov 6 1943 to Nov 30 1943

that I last saw him alive on Nov 29 and that death occurred on the date and hour stated above.

Immediate cause of death Maemia Duration 3 wks

Due to Ac. Pyelitis Duration 3 wks

Due to Renal abscess
Prostatic obstruction
(benign hypertrophy) ?

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1/21 PHYSICIAN

Of autopsy Multiple renal abscess
Benign hypert. prostate
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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?

(Specify type of place) While at work? (e) Means of injury.....

23. Signature Arthur E. ... (M. D. or ...)

Address 539 N. Grand Date signed 11/30/43

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

MOTHER FATHER

844

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 *Albert G. Hoff*

Licensed Embalmer No. *2971*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. DeeRegistration District No. 318Primary Registration District No. 1003Registrar's No. 10519

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:
 (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)3. (a) PRINT
FULL NAME.....Alexander E Howery3. (b) If veteran,
name war.....3. (c) Social Security
No.....4. Sex M 5. Color or race W
6. (a) Single, widowed, married,
divorced m6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... year.....7. Birth date of deceased.....
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
64 min.9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....
(City, town, or county) (State or foreign country)14. Maiden name.....
(City, town, or county) (State or foreign country)15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 12-18-43
(Date received local registrar)J F Bredek
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town.....
 (If outside city or town limits, write "RURAL")
 (d) Street No.....
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....
year..... hour..... minute..... M.21. I hereby certify that I attended the deceased from....., 19.....;
that I last saw him..... alive on....., 19.....;
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:

Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

67

36490