

No. 2  
8-43  
7-39  
X37823

FILED JAN 16 1945  
318

Primary Registration District No. **1003**

Registrar's No. **147**

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: **JEWISH HOSPITAL**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 DAYS**  
In this community **32 years**  
years, months or days (Specify whether)

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. **1215<sup>th</sup> BLACKSTONE**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **JOSE SPBITZ**

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 **MARRIED**  
6. (b) Name of husband or wife **HILDA SPRITZ** 6. (c) Age of husband or wife if alive **UNKNOWN** years  
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **64** Months Days If less than one day hr. min.

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

10. Usual occupation **BARBER**

11. Industry or business

12. Name **VIDA LAOB SPRITZ**

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

14. Maiden name **MOLINE**

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

16. (a) Informant **Hilda Spritz**

(b) Address **1215<sup>th</sup> Blackstone**

17. (a) **BURIAL** (b) Date thereof **1-8-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CHEVRAH KADISHA**

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

(b) Address **4469 Washington**

19. (a) **JAN 8 1945** (b) **J. B. Brudeck**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **7**  
year **1945** hour **4** minute **44 P.M.**

21. I hereby certify that I attended the deceased from **1/3**, 19**45**, to **1/7**, 19**45**.  
that I last saw h. **1/7** alive on **1/7**, 19**45**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **4 days**

Due to  
Due to  
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) (c) Means of injury

23. Signature **David Feigman** (M. D. or other) **MD**  
Address **Jewish Hosp.** Date signed **1/7/45**

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

**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 *J. G. Overhandler*  
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.**