

FILED MAR 9 1945

Registration District No. **213** Primary Registration District No. **1003**

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 _____ (Specify whether)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME **MORRIS BLITZ**
 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 **Massie Blitz** 6. (c) Age of husband or wife if alive **63** years
 7. Birth date of deceased **July 1 1874**
 (Month) (Day) (Year)

8. AGE: Years **70** Months **7** Days **17** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired Grocer**

MOTHER FATHER { 12. Name **Unknown**
 13. Birthplace **Russia**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Russia**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Massie Blitz**
 (b) Address **1464 Laurel**

17. (a) **Burial** (b) Date thereof **2--20--45**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Chesed Shel Emeth Cem.**

18. (a) Signature of funeral director **H. Renda Kopf**
 (b) Address **5216 Delmar Blvd.**

19. (a) **FEB 19 1945** (b) **J. F. Bredeck**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **000**
 (d) Street No. **1464 Laurel** (If rural, give location) **17**
 (e) Citizen of foreign country? _____ (Yes or No) **1**
 If yes, name country _____ **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **18**
 year **1945** hour **11** minute **45** P. M.
 21. I hereby certify that I attended the deceased from **Dec 21 1944** to **Feb 18 1945**
 that I last saw him ~~was~~ alive on **2/18/45** and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of lung (left) 6 mm
 Embolus of left ilium**
 Duration _____

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) **H7**

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 **depos phelma** (M. D. or other) **msd**
 Address **634 N. Federal** Date signed **2/19/45**

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

H. Burgess

Licensed Embalmer No. 4029

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.