

11500

State File No.

FILED MAY 3 1945 8

1003

Registrar's No. 3711

Registration District No.

Primary Registration District No.

X37823

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

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:
CHILDRENS 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 Harry Max Ludwig
 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 _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years _____ days
 7. Birth date of deceased: 4 17 1945
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>7</u>	hr. _____ min. _____

9. Birthplace St. Louis MO _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

MOTHER FATHER

11. Industry or business newborn
 12. Name FRED WODWIG
 13. Birthplace ST. LOUIS MO _____
(City, town, or county) (State or foreign country)
 14. Maiden name MARIONA A. ARONOWITZ
 15. Birthplace GERMANY _____
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Ludwig
 (b) Address 5804 Theodosia

17. (a) Rural (b) Date thereof 4-25-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shol Epheth
Oberlinville
 18. (a) Signature of funeral director _____
 (b) Address 4467 Washington

19. (a) APR 26 1945 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

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. 5804 Theodosia
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 24
 year 45 hour 10 minute 30 A.M.
 21. I hereby certify that I attended the deceased from April 23 1945, to April 24 1945;
 that I last saw him alive on 4-24 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage life
 Due to hemorrhagic disease of newborn life
 Due to _____

Other conditions pneumonia _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations life
 Of autopsy cerebral hemorrhage
 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 _____ (M. D. or other) MD
 Address _____ Date signed 4-24-45

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.

Not Embalmed

Signed *[Signature]*
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.