

DM-8-43  
 v. 5-17-39  
 X37823

**FILED JUN 9 1945** 818 Registration District No. Primary Registration District No. **1003** Registrar's No. **4295**

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

1. PLACE OF DEATH:  
 (a) County St. Louis, Missouri  
 (b) City or town St. Louis, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis's Children's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 hour, 40 min.  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County 95  
 (c) City or town Weingarten  
 (If outside city or town limits, write "RURAL.") 0  
 (d) Street No. 1 (If rural, give location) NR.  
 (e) Citizen of foreign country? 1 (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ruth Elizabeth Moskowitz  
 3. (b) If veteran, name war -- 3. (c) Social Security No. --  
 4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, Divorced Single  
 6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive -- years  
 7. Birth date of deceased March 18- 1945  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 17  
 year 45 hour 7 minute 40 p.m.  
 21. I hereby certify that I attended the deceased from May 17, 1945  
 to May 17, 1945  
 that I last saw her alive on May 17, 1945  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
1 29 hr. min.

Immediate cause of death Congenital Syphilis  
Septicemia  
 Due to \_\_\_\_\_  
 Due to 307  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Duration \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Charles Moskowitz  
 13. Birthplace New York  
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Elizabeth Deenihan  
 15. Birthplace New York  
 (City, town, or county) (State or foreign country)

16. (a) Informant VM Walker  
 (b) Address 500 So. Kingshighway

17. (a) Anatomical Board (b) Date thereof JUN 1 1945  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director W. Richter  
 (b) Address 3500 Rutger

19. (a) JUN 9 1945 (b) J. F. Bredeck  
 (Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

(Specify type of place)  
 While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
 23. Signature R. J. Blatter (M. D. or other) \_\_\_\_\_  
 Address 100 So. N. Kingshighway Date signed \_\_\_\_\_

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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.....

Licensed Embalmer No.....

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.**