

**FILED MAY 17 1945**

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 1039

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(b) City or town Royal St. Ferdinand Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: JEWISH SANATORIUM  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 40 years (Specify whether years, months or days)  
In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5808 Terry  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JACOB WROBEL

3. (b) If veteran, name war no  
3. (c) Social Security No. 498-01-2327

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Sara Wrobel  
6. (c) Age of husband or wife if alive 10 years (Year) 1891

7. Birth date of deceased October 10 1891  
(Month) (Day) (Year)

8. AGE: Years 55 Months 6 Days 20  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Tailor

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

12. Name Israel Wrobel

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

14. Maiden name Miriam Funetz

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

16. (a) Informant Harry Smith

(b) Address 4951 Laclede

17. (a) burial (b) Date thereof 5-1-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bnai Amoona

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson Avenue

19. (a) MAY 2 1945 (b) E. G. McPherson MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30  
year 1945 hour 5 minute 50 A.M.

21. I hereby certify that I attended the deceased from march, 5  
1944 to April 30 1945  
that I last saw him alive on April 30 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Arterio-sclerotic heart disease  
Duration: Few years

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: none  
(Include pregnancy within 3 months of death)

Major findings: Of operations: none

Of autopsy: none

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)  
(e) Means of injury \_\_\_\_\_

23. Signature John Simpson (M. D. or other) \_\_\_\_\_  
Address JEWISH SANATORIUM Date signed 4/30/45

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

MOTHER FATHER

312  
17-48

MAY 26 1945

MAY 19 1945

**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. 1597

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.**