. S. No. 2
00M—2-43
ev. 5-17-39
Ex. 1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 16 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25001

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1757

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christian Old Peoples Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis
(c) City or town: University City
(If outside city or town limits, write "RURAL")
(d) Street No.: 6811 Kingsbury
(If rural, give location)
(e) Citizen of foreign country? Alien 1589266 (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Sam Horwitz
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: widower
6. (b) Name of husband or wife: Lena Horwitz
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: July (Month) 15, (Day) 1875 (Year)
8. AGE: Years 70 Months 11 Days 27 If less than one day ____ hr. ____ min.
9. Birthplace: Yampole Volhynia Poland (City, town, or county) (State or foreign country)
10. Usual occupation: Merchant
11. Industry or business: Ready to wear and DG.
MOTHER FATHER
12. Name: Moses Horwitz
13. Birthplace: Volhynia Poland (City, town or county) (State or foreign country)
14. Maiden name: Bessie Tema Melamed
15. Birthplace: Volhynia Poland (City, town, or county) (State or foreign country)
16. (a) Informant: Information on file
(b) Address: 4715 McPherson
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/13/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Chesed Shel Emeth
18. (a) Signature of funeral director: Berger Memorial
(b) Address: 4715 McPherson ave.
19. (a) 7-13-45 (Date received local registrar) (b) E. G. McGavin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1945 hour 8 minute A. M.
21. I hereby certify that I attended the deceased from 3/27/39 to 7/6/45 that I last saw him alive on 7/6/45 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Discount Chronic Myocarditis	5/1/44
Due to: Myocardial damage	
Due to: Hypertension	
Other conditions (Include pregnancy within 3 months of death): 93d.	

Major findings:
Of operations ____
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature: D. C. Jr. (M. D. ~~another~~) M.D.
Address: Lenmar Club Bldg. Date signed 7/12/45

(Licensed Embalmer's Statement on Reverse Side)

JUL 19 1945

NOV 8 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.