

FILED OCT 12 1945
318

Registration District No.

Primary Registration District No.

1003

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether
In this community 34 1/2 YEARS
years, months or days)

3. (a) PRINT FULL NAME MORRIS WACHTER

3. (b) If veteran, name war No
3. (c) Social Security No. 500-24-5629

4. Sex Male / 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sadie Wachter
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Jan. 21, 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 8 13 hr. min.

9. Birthplace New York City New York
(City, town, or county) (State or foreign country)

10. Usual occupation Meat Cutter

11. Industry or business Meat Market

12. Name Unk. Wachter

13. Birthplace Unk. Unk. 9
(City, town, or county) (State or foreign country)

14. Maiden name Unk.
15. Birthplace Unk. Unk. 4
(City, town, or county) (State or foreign country)

16. (a) Informant Sadie Wachter

(b) Address 1908 Angelica St.

17. (a) Burial (b) Date thereof 10/6/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cem.

18. (a) Signature of funeral director Suedmeyer & Sons

(b) Address 3934 N. 20 Street.

19. (a) OCT 5 1945 (b) J. F. Predeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 00026
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1908 Angelica St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4th
year 1945 hour 9:05 minute A. M.
21. I hereby certify that I attended the deceased from 9/20/45
to 10/4/45, 1945, to 10/4/45, 1945;
that I last saw him alive on 10/4/45
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral nephrosclerosis
Due to.....
Due to.....
Other conditions Bleeding prostatic hypertrophy
(Include pregnancy within 3 months of death)
Major findings of operations.....
Of autopsy.....
Duration
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) (e) Means of injury.....
While at work?.....
23. Signature A. Lee Howell (M. D. or other) MD.
Address 1515 Lafayette Date signed 10/4/45

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.

Signed *Penneth Wm Jones*

Licensed Embalmer No. *4224*

P. O. Address *3423 Clara*

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.