

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X3657

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
#42001  
FILED OCT 25 1945  
318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31887  
Registrar's No. 9084

Registration District No. Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis, Mo.  
(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 7 weeks  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis 617  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2833 Abner Place 9  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country

3. (a) PRINT FULL NAME HENRY FUCHS  
(b) If veteran, name war  
(c) Social Security No. 489-18-8444

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 20th  
year 1945 hour 3:00 minute A.M.

4. Sex Male (d) 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lucia  
6. (c) Age of husband or wife if alive 56 years  
7. Birth date of deceased Sept. 10 1886  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 19 to 10/20/45  
that I last saw him alive on 10/20/45  
and that death occurred on the date and hour stated above.

8. AGE: Years 59 Months 1 Days 10  
If less than one day hr. min.

Immediate cause of death: Carcinoma of Jaw  
Due to  
Due to  
Other conditions: (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy  
Duration

9. Birthplace Germany  
(City, town, or county) (State or foreign country)  
10. Usual occupation Majestic Stove Co.

MOTHER, FATHER  
11. Industry or business Martin Fuchs  
12. Name  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Lucia Fuchs  
(b) Address 2833 Abner Place  
17. (a) Burial (b) Date thereof Oct. 28, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation Memorial Park Cemetery  
18. (a) Signature of funeral director Wacker Helderle  
(b) Address 3634 Gravois Ave.  
19. (a) OCT 22 1945 (Date received local registrar)  
J. J. Brudick (Registrar's signature)

(Specify type of place)  
(e) Means of injury  
23. Signature A. Lee Stewart (M. D. or other) M.D.  
Address 1515 Lafayette 10/20/45 Signed

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

**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.....

*Frank J. [Signature]*

Licensed Embalmer No. *2045*

P. O. Address *[Signature]*

**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.**