

Registration District No. **318** 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
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Firmin Desloge Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME Joseph Gerwitz

(b) If veteran, name war..... Nil

3. (c) Social Security No. Unknown

4. Sex Male 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.....
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>5</u>	<u>22</u>hr.min.

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

10. Usual occupation Cabinet Maker

11. Industry or business.....

MOTHER FATHER { 12. Name Simon Gerwitz

13. Birthplace Unknown Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Reck

15. Birthplace Unknown Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant William Gerwitz

(b) Address 2027 De Soto Ave.

17. (a) Burial (b) Date thereof 11-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 21 1945 J. F. Brednich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5079a Durant Ave.
(If rural, give location)

(e) Citizen of foreign country?.....
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
year 1945 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from NOV. 14-1
1945 to 11-20-45, 1945

that I last saw him alive on 11-20-45, 19.....

and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure

Due to cardiac. Pers. vascular disease

Due to 52

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operation Chronicity of Heart - Urinary prostate

Of autopsy Chronicity of Heart - C.V. R. disease

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) (c) Months of injury

23. Signature Leuro R. Desord (M. D. or other)
Address 8720 Dur St. St. L. Date signed 11/21/45

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 *John Goswami*
.....
Licensed Embalmer No. *3398*
.....

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.