

S. No. 2
 10M-5-43
 Rev. 5-17-39
 I X38671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
FILED JAN 11 1946 STANDARD CERTIFICATE OF DEATH

State File No. **39159**
 Registrar's No. **11171**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis, Missouri
(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
(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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town St. Louis Richmond Heights
(If outside city or town limits, write "RURAL")
 (d) Street No. 7532 Warner Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME JULIUS FUCHS
 3. (b) If veteran, name war _____
 3. (c) Social Security No. Widower
 4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 8th 1875
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 26th
 year 1945 hour 8:20 minute A M.
 21. I hereby certify that I attended the deceased from 7/25/45
 _____, 19____, to 12/26/45, 19____
 that I last saw him in alive on 12/26/45, 19____
 and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 5 Days 18
 If less than one day _____ hr. _____ min.

Immediate cause of death _____
Arteriosclerotic heart disease
 Due to _____
 Due to _____
 Other conditions Psychosis with cerebral arteriosclerosis
(Include pregnancy within 5 months of death)

9. Birthplace _____
(City, town, or county) (State or foreign country)
 10. Usual occupation Retired
 11. Industry or business _____
MOTHER FATHER {
 12. Name S. Fuchs
 13. Birthplace Unknown 7
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown 7
(City, town, or county) (State or foreign country)
 16. (a) Informant Mrs. Wissmann
 (b) Address 7532 Warner Ave.
 17. (a) Burial (b) Date thereof Dec. 28, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Matthews Cemetery
 18. (a) Signature of funeral director Walter Reddick
 (b) Address 3634 Gravois Ave.
 19. (a) DEC 28 1945 (b) J. F. Bredick
(Date received local registrar) (Registrar's signature)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 Major findings: Of operations _____
 Of autopsy _____
 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 Philip F. O. Seitz 1514 Lafayette 12/26/45 m.S.
(Date received local registrar) (Address) (Date 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..... *Robert Wheeler*

Licensed Embalmer No..... *2178*

P. O. Address..... *St. Louis, Mo.*

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.