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

4-7-47

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11757

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 743

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6505 San Bonita
(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 96

(c) City or town Clayton 2
(If outside city or town limits, write "RURAL") 3

(d) Street No. 6505 San Bonita 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Herman Samuel Ehrenreich

3. (b) If veteran, name war 1st World

3. (c) Social Security No. none

4. Sex Male

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Margaret Weiss Ehrenreich

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased May (Month) 15 (Day) 1878 (Year)

8. AGE: Years 68 Months 10 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Hungary 4 (State or foreign country)

10. Usual occupation Doctor of Medicine

11. Industry or business .....

FATHER
12. Name Henry Ehrenreich
13. Birthplace ..... (City, town, or county) Hungary 1 (State or foreign country)

MOTHER
14. Maiden name Hannah Weiss
15. Birthplace ..... (City, town, or county) Hungary 4 (State or foreign country)

16. (a) Informant Mrs Herman Ehrenreich
(b) Address 6505 San Bonita

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer
(b) Address 4356 Lindell Blvd

19. (a) 4-2-47 (Date received local registrar) (b) Ruth J Allen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31 year 1947 hour 6:00 ~~A.M.~~ M.

21. I hereby certify that I attended the deceased from Feb 22 '47 ....., 19..., to Mch 21, 1947; that I last saw him alive on Mch. 29, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Hypertension	1 yr.
Due to 946	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? 0
(Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature Chas. Wolff (M. D. ~~or other~~)

Address 1418 Franklin Date signed 4/1/47

(Licensed Embalmer's Statement on Reverse Side)

APR 9 1947

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 S. Dennehy

Licensed Embalmer No. 4194

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.