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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 15 1947

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

Primary Registration District No.

State File No. 40262

Registrar's No. 10733

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: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME DR. JACK HAROLD TRITT

3. (b) If veteran, name war

3. (c) Social Security No.

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 Unknown
(Month) (Day) (Year)

8. AGE: Years About 31 Months - Days - If less than one day hr. min.

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

10. Usual occupation Physician

11. Industry or business

FATHER
12. Name Samuel Tritt
13. Birthplace (City, town, or county) Canada (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Canada (State or foreign country)

16. (a) Informant Joseph Tritt
(b) Address Winnepeg, Canada

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-20-47 (Month) (Day) (Year)
(c) Place: burial or cremation Fort William, Canada

18. (a) Signature of funeral director Herman Rudolph & Son Inc
(b) Address 5216 Delmar Blvd.

19. (a) NOV 22 1947 (Date received local registrar) (b) J. F. Bracken (Registrar's signature)

NOV 22 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18
year 1947 hour 10 minute 00 A.M.

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

Immediate cause of death — Duration
Neurogenic Heart
Due to
Disease
Due to
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

10733

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.....Van M. Sizemore.....

Licensed Embalmer No.....4343.....

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.