No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 4 1948

Registration District No. 7

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39017

Primary Registration District No. 6076

Registrar's No.

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Rural: Airport Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: JEWISH SANATORIUM
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 5 years 3 months 2 days (Specify whether years, months or days)
In this community: (unk)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 96
(c) City or town: Robertson
(If outside city or town limits, write "RURAL")
(d) Street No.: Jewish Sanatorium
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: HIRSCH SCHWARZ

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: male

5. Color or race: white

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

6. (b) Name of husband or wife: Ida (unk)

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

7. Birth date of deceased: UNKNOWN (Month) (Day) (Year)

8. AGE: Years: ab. 88 | Months | Days | If less than one day: hr. min.

9. Birthplace: Minz (City, town, or county) USSR (State or foreign country) 6

10. Usual occupation: Dentist (retired)

11. Industry or business:

MOTHER FATHER

12. Name: (Unk) Schwarz 6

13. Birthplace: (City, town, or county) USSR (State or foreign country)

14. Maiden name: (Unk) 6

15. Birthplace: (City, town, or county) USSR (State or foreign country)

16. (a) Informant: Mrs. Victoria Kropushek
(b) Address: 7117 W. Florissant

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 11/9/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Mount Olive Hebrew

18. (a) Signature of funeral director: Berger Memorial
(b) Address: 4715 McPherson

19. (a) 11-9-48 (Date received local registrar) (b) Carl E. Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: November day: 7
year: 1948 hour: ten minute: 30 A.M.

21. I hereby certify that I attended the deceased from: August 5, 1943, to: November 7, 1948; that I last saw him alive on: November 7, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cancer of rectum	about 6 years
Due to:	
Due to: 46 d	
Other conditions: (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN

Underline the cause of 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: [illegible] (M. D. or other)
JEWISH SANATORIUM
Address: Date signed: 11-7-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Ballwin Road, St. Louis County,
P. O. Robertson, Mo.

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 _____

Licensed Embalmer No. 4239

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.