N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DEC'D MAR 13 1939

791

4738
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 1431

(c) City St. Louis (d) Street No. 2655 Shenandoah St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 252 William C. Reising

(a) Residence, No. 2655 Shenandoah St. 23
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Sophie Reising

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 10 1879

7. AGE: YEARS 59 | MONTHS 7 | DAYS 2 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. .....
9. Industry or business in which work was done, as saw mill, bank, etc. Grocery Prop
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Mo. 0

FATHER
13. NAME: William J. Reising 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Mo. 9

MOTHER
15. MAIDEN NAME: Amelia Ruck
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Sophie Reising 2655 Shenandoah Av

18. BURIAL, CREMATION, OR REMOVAL
PLACE N. St. Marcus DATE 2-15 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Wett Bros L & N Co 2929 S. Jefferson Av.

20. FILED FEB 14 1939 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Feb. 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from February 5th, 1936 to February 12th, 1939
I last saw him alive on February 12th, 1939 Death is said to have occurred on the date stated above, at 11 p. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic myocarditis	indefinite
Chronic endocarditis	

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Other contributory causes of importance:
Chronic asthma
Acute nephritis caused by chronic nephritis — 2 mos

Name of operation None Date of .....
What test confirmed diagnosis? All usual Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify .....
(Signed) [signature], M. D.
(Address) 2278 S. Jefferson

Licensed Embalmer's Statement on Reverse Side)

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, Paul A. Shanklin, or by .....

Registered Apprentice No. ....., working under my personal supervision.

Signed Paul A. Shanklin

Licensed Embalmer No. 3479

P. O. Address 9999 S. Jefferson

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, above space should be left blank.