

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34349
Registrar's No. 8887

Registration District No. 791 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)

NOV 13 1939

3. (a) PRINT FULL NAME William F. Reichenbacher

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 Widowed

6. (b) Name of husband or wife Emma Reichenbacher 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 6 1861
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Ret. Yeast Salesman

11. Industry or business _____

12. Name Gottfried Reichenbacher

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

14. Maiden name Margaret Kippel
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Julia Reichenbacher

(b) Address 4749 Morganford

17. (a) Burial (b) Date thereof Oct. 20-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Pauls Church Yard

18. (a) Signature of funeral director Wm. Schumacher

(b) Address 3013 Keramec St.

19. (a) OCT 19 1939 (b) J.P. Baulick
(Received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 20
(d) Street No. 2821 University St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17
year 1939 hour 8 minute 40 P. M.

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

Immediate cause of death Fracture of left hip; Arteriosclerosis
suffered in fall to floor in his
home, October 14, 1939, about
4.00 P.M. ACCIDENT

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ACCIDENT
(b) Date of occurrence 10-14-1939
(c) Where did injury occur? St. Louis
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
(Specify type of place) Means of injury _____

While at work? _____
23. Signature Joseph M. Zeller (M.D. or other)
Address Deputy Coroner Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

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

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.

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.....

George J. Pelsaert....., Registered Apprentice No. _____
working under my personal supervision.

Signed George J. Pelsaert.....
Licensed Embalmer No. 2906

P. O. Address 3013 My name

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.