

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.

Registration District No. 784

Primary Registration District No. 101

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:
603 Polo Drive.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Dont know.
years, months or days _____

NOV 9 1939

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Clayton
(If outside city or town limits, write "RURAL")
(d) Street No. 603 Polo Drive.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Lulu F. Rinkel.

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband Geo. W. Rinkel.

6. (c) Age of husband 80 years alive _____

7. Birth date of deceased January 23, 1864.
(Month) (Day) (Year)

8. AGE:

Years 75 Months 8 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace

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

10. Usual occupation

Housewife

11. Industry or business

at home

MOTHER FATHER

12. Name
13. Birthplace
14. Maiden name
15. Birthplace

Fred W. Hinterthuer.
? Germany.
Whilmine Bartold.
? Louisiana.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Mr. Geo. W. Rinkel.

(b) Address

603 Polo Drive.

17. (a)

Burial

(b) Date thereof 10-11-1939
(Month) (Day) (Year)

(c) Place: burial Oak Grove Mausoleum.

18. (a) Signature of funeral director

Geo. L. Pleitsch Inc.

(b) Address

5966-68 Easton Ave.

19. (a)

OCT 9 1939

(b) (Registrar's signature) [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8th.
year 1939. hour 11 minute 45 A. M. P.

21. I hereby certify that I attended the deceased from Oct 4 to Oct 8, 1939.
that I last saw her alive on Oct 8, 1939.
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Infarction
Duration 3 days.
Due to Senility

Due to _____
Other conditions Diabetes
(Include pregnancy within 3 months of death) 9 Mo

Major findings:

Of operations _____

Of autopsy No

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?

While at work?

(Specify type of place) (e) Means of injury _____

23. Signature

W. J. Meador

(M. D. or other) 1

Address

Clayton Mo.

Date signed 10/9/39

Dr. A. L. Meador
2 Central dr.

8762
2 to 4
Parkview, 8164

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 3454

David C. Gibson

....., Registered Apprentice No.....

working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

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, above space should be left blank.

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

Do not use this space.

1. PLACE OF DEATH

County St. Louis
Township Clayton
City Clayton (No.)

Registration District No. 784
Primary Registration District No. 121

File No. 37130
Registered No. 1774
St. Ward

2. FULL NAME

(a) Residence, No. St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS 75 MONTHS 8 DAYS 15 If LESS than 1 day, hrs. min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.

19. UNDERTAKER (ADDRESS)

20. FILED 19. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 8 1924

22. I HEREBY CERTIFY, That I attended deceased from , 19. , to , 19.

I last saw h. alive on , 19. . Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Hypostatic pneumonia
Senility

Other contributory causes of importance: Arteriosclerosis, Neurosis 9 mo

Name of operation Date of 8/14

What test confirmed diagnosis? Was there an autopsy?

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?

If so, specify (Signed) N. L. Meador, M. D.

(Address) Clayton, Mo.

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TEMPORARY

