

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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. 2023

Primary Registration District No. 200

Registrar's No. 2023

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Roch
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Roch Hospital 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1271 days
 (Specify whether years, months or days)

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. 3602 West Florissant
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 34 years.

3. (a) PRINT FULL NAME Paul Reimer 56li

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 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. 6 13 87
 (Month) (Day) (Year)

8. AGE: Years 52 Months 5 Days 4 If less than one day 10 hr. 15 min.

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

10. Usual occupation Wagon-maker

11. Industry or business _____

12. Name Carl Reimer

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

14. Maiden name Maria Kretschmer

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

16. (a) Informant's own signature Roch Hospital

(b) Address Roch, Missouri

17. (a) _____ (b) Date thereof 11/20/39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation KRARGER-YOSS FIX INC.

18. (a) Signature of funeral director KRARGER-YOSS FIX

(b) Address 3402 N. Kingshighway

19. (a) NOV 19 1939 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17
 year 1939 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from June 15, 1937, to Nov 17, 1939;
 that I last saw him alive on 11-17, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Hyposplenism with cerebral accident

Due to 23

Due to Pulmonary Tuberculosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Pulmonary ery Tuberculosis

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 William Starks (M. D. or other) _____

Address Roch Hospital Date signed 11/17/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

J. J. Sullivan

Licensed Embalmer No. 1122

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.