

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH ✓

State File No. **14732**

Registration District No. **229** Primary Registration District No. **5211** Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Crawford**
 (b) City or town **Boone**
 (c) Name of hospital or institution: **Rural Boone**
 (d) Length of stay: In hospital or institution **Home 2**
 In this community **15 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **mo** (b) County **Crawford**
 (c) City or town **Rural**
 (d) Street No. **RR # 2**
 (e) If foreign born, how long in U. S. A.? **here a child** years.

8. (a) PRINT FULL NAME **MARY L. REITZ 320**

8. (b) If veteran, name war **8. (c) Social Security No.** _____

4. Sex **Female** **5. Color or race** **W** **6. (a) Single, widowed, married, divorced** **Widowed**
6. (b) Name of husband or wife **Widowed 9 Reitz** **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **11 1873**
 (Month) (Day) (Year)

8. AGE: Years **66** Months **5** Days **15** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business **None**

MOTHER FATHER
12. Name **Louis Schremlin**
13. Birthplace **France**
14. Maiden name **Christine Keteily**
15. Birthplace **France**

16. (a) Informant **Louis M. Reitz**
(b) Address **Boone mo**

17. (a) _____ **(b) Date thereof** **April 28 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Leadberg mo**

18. (a) Signature of funeral director **W. F. Twinn**

(b) Address **Leadberg mo**

19. (a) **4-26** **(b)** **W. F. Twinn**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **26th**
 year **1940** hour **7:15** minute _____ P. M.
21. I hereby certify that I attended the deceased from **4-24-1940**
4-20-1940 to **4-26-1940**, 19**40**
 that I last saw her alive on **4-26-1940**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **acute nephritis**
 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) _____
 (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?
205 (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature **W. F. Twinn** (M. D. or other) _____
Address **Leadberg mo** Date signed **4-26-1940**

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

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

120

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 _____

RECEIVED

Registered Apprentice No. _____

working under my personal supervision.

District Health Officer No. 5,

District File Number 540 598

Date Filed 5/24/92

Signed _____

Licensed Embalmer No. 12692

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.

Registration District No. **229**

Primary Registration District No. **3211**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Crawford**
 (b) City or town **Boone T.P.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME **Mary L. Reitz**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

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

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

8. AGE: Years **66** Months **5** Days **15** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **26** year **1990** hour _____ minute _____ M.

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

Immediate cause of death _____

Due to **I have no earlier dates on case,**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **170**

Major findings: Of operations _____

Of autopsy _____

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. Signatur **W. F. Brown** (M. D. or other) _____

Address **Leasburg, Mo** Date signed _____

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

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

SUPPLEMENTAL

S-14732