

313

1003

Primary Registration District No. \_\_\_\_\_

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

FILED JUN 17 1943

Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Johns Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Weeks  
(Specify whether years, months or days)

In this community 50 Years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3925 Flora Place  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William A. VanRhein

3. (b) If veteran, name war World War #1

3. (c) Social Security No. 488-01-3263

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Gesina VanRhein

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased July 17 1891  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

51	10	19	hr. min.
----	----	----	----------

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

10. Usual occupation Druggist

11. Industry or business \_\_\_\_\_

12. Name William G. VanRhein

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

14. Maiden name Eleanor Coyle

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

16. (a) Informant Mrs. Gesina Van Rhein

(b) Address 3925 Flora Place

17. (a) Burial (b) Date thereof 6-9-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Durnally

(b) Address 3840 E. 12th Blvd.

19. (a) JUN 8 1943 (b) J. D. Brudick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6  
year 1943 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from May 1, 1943, to June 6, 1943  
that I last saw h. 12 alive on June 6, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death—  
Respiratory failure

Due to Longueal tuberculosis (1)

Due to Pulmonary tuberculosis  
Pulmonary embolism

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. Signature Bernard J. Mahon (M. D. or other) \_\_\_\_\_  
Address 634 No. Grand Date signed 6/7/43

M. J. Mahon

*Dr. M. J. Washburn*  
*Rev. J. B. J. Washburn*

JUN 17 1943

*1 Pm*

**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 *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address *3840 Lindell*

**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, fact should be so stated above.**