V. S. No. 2
00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 14 1945

State File No. 19139

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 5502

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

(d) Length of stay: In hospital or institution 6 hours (Specify whether

In this community 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") 24

(d) Street No. 3162 Ohio Av. (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Minnie A. Reifeiss

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife William Reifeiss

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

7. Birth date of deceased March (Month) 23 (Day) 1889 (Year)

8. AGE: Years 56 Months 3 Days 1 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Gotthold Weder
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Hei
15. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mary Weder

(b) Address 3162 Ohio Av.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-45 (Month) (Day) (Year)

(c) Place: burial or cremation N. St. Marcus Cem

18. (a) Signature of funeral director Witt Bros Lt Nw

(b) Address 2929 S. Jefferson Av.

19. (a) JUN 25 1945 (Date received by registrar) J. F. Bredeck (Registrar's signature)

JUN 25 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1945 hour 2 minute 50 A.M.

21. I hereby certify that I attended the deceased from June 24, 1945 to June 24, 1945 that I last saw her alive on June 24, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Increased intracranial pressure	4 months
Due to Tumor of right frontal lobe	
Due to Malignant	
Other conditions Hypertensive cardiovascular disease (Include pregnancy within 3 months of death)	
Major findings: Of operations 5 H	
Of autopsy Tumor of rt. frontal lobe	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature F R Bradley O (M. D. or other)

Address Barnes Hospital, Date signed 6-24-45

(Licensed Embalmer's Statement on Reverse Side)

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 Ronald Gahnke

Licensed Embalmer No. 3917

P. O. Address St Louis Mo.

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.