

FILED SEP 1 1945

Registration District No. _____

Primary Registration District No. 3017

Registrar's No. 98

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

1. PLACE OF DEATH:
 (a) County COOPER
 (b) City or town BOONVILLE Mo-
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)
 In this community 5 DAYS

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County MORGAN 71
 (c) City or town SYRACUSE Rural 0
(If outside city or town limits, write "RURAL")
 (d) Street No. RFD 1
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM REIN
 3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife SALLIE REIN 6. (c) Age of husband or wife if alive 81 years
 7. Birth date of deceased JANUARY 8 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>7</u>	<u>15</u>	hr. _____ min. _____

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

10. Usual occupation FARMER

11. Industry or business FARMING

12. Name DR. LEWIS REIN

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

14. Maiden name UNKNOWN

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

16. (a) Informant MRS WILLIAM REIN

(b) Address OTTERVILLE MISSOURI

17. (a) REMOVAL (b) Date thereof AUG. 24, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OTTERVILLE, MO

18. (a) Signature of funeral director STEGNER & KOENIG

(b) Address BOONVILLE, MO.

19. (a) 8-24-45 (b) Dr. Chas. Swapp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month AUGUST day 24
 year 1945 hour 1:30 minute a M.

21. I hereby certify that I attended the deceased from Aug 20, 1945, to Aug 24, 1945
 that I last saw ~~him~~ her alive on August 23, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
 Duration 4 days

Due to Chronic Glomerular Nephritis Saccul
yr.

Due to _____

Other conditions Pericarditis & Effusion 1 week
(Include pregnancy within 3 months of death)

Major findings:
 Of operations 13 W
 Of autopsy As notes above
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.H. Ziegler (M. D. or other) M.D.

Address Bonville Mo. Date signed 8/24/45

NOV 29 1950

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.....

James W. Stegner

Licensed Embalmer No. *3780*

P. O. Address. *Boonville, 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.