No. 2
8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 30 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27691

Registration District No. 160 Primary Registration District No. 3030 Registrar's No. 212

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town Festus
(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 years, months or days)
In this community 63 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jefferson 50
(c) City or town Festus
(If outside city or town limits, write "RURAL")
(d) Street No. 103 E. Frisco 1
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jennie Reheisse
3. (b) If veteran, name war No
3. (c) Social Security No.
4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Peter Reheisse
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Apr. 15, 1852 (Month) (Day) (Year)
8. AGE: Years 93 Months 2 Days 9 If less than one day hr. min.
9. Birthplace France (City, town, or county) 5 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Joseph Moye
13. Birthplace France 5 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Victoria ?
15. Birthplace Victoria ? France 5 (City, town, or county) (State or foreign country)
16. (a) Informant Joe Reheisse
(b) Address Festus, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/45 (Month) (Day) (Year)
(c) Place: burial or cremation Festus Catholic Cemetery
18. (a) Signature of funeral director H. L. Vinyard
(b) Address Festus, Mo.
19. (a) July 29, 1945 (Date received local registrar) (b) Virginia Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1945 hour 1 minute P.M.
21. I hereby certify that I attended the deceased from July 19, 1945 to July 24, 1945 that I last saw him alive on July 24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia	2 days
Due to Injuries received in a fall July 17 1945	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy

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) 150
(b) Date of occurrence
(c) Where did injury occur? Festus Jefferson Mo (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 J. J. Gunnerford M.D. (M. D. or other)
Address Crystal City Mo Date signed 7/25/45

135

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 8-29-45

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 H. H. Wingard

Licensed Embalmer No. 3010

P. O. Address Joplin 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.

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3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 160 Primary Registration District No. 3030 Registrar's No. 212

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Festus
(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)

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Jennie Reheisse

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 Apr (Month) 15 (Day) 1855 (Year)

8. AGE: Years 93 Months 8 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July 24
year 1945 hour 10 minute M.

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

Immediate cause of death

Due to

Due to Fall at home, injury & left arm & general condition

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 186a-5 1/1

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 [illegible] (M. D. or other)

Address Crystal City Mo Date signed 9/1/45

S-27691