. No. 2
1—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 5 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39685
Registrar's No. 11193

Registration District No. 318 Primary Registration District No. 1003

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 Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DEACESED:

(a) State Mo (b) County St Louis
(c) City or town 6906 Waterman
(If outside city or town limits, write "RURAL")
(d) Street No. U. City Mo. NR
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Beatrice Reinert
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race W.
6. (a) Single, widowed, married, divorced W. 21
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 9 (Day) 1894 (Year)

8. AGE: Years 51 Months 4 Days 9 If less than one day hr. min.

9. Birthplace Chicago (City, town, or county) Ills (State or foreign country)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name George L Down
13. Birthplace Ontario Canada (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Betty Jane Reid
(b) Address 6906 Waterman
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Walhalla Cemp
18. (a) Signature of funeral director Lewis H Bopp Inc
(b) Address Kirkwood, MO
19. (a) DEC 21 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 18 year 1945 hour 6 minute 25 M.
21. I hereby certify that I attended the deceased from Dec. 11, 1945 to Dec 18, 1945 that I last saw her alive on Dec 18, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cirrhosis of Liver — Duration

Due to

Due to

Other conditions Nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Cirrhosis of liver, Nephritis

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 J. W. Nallin M.D. (M. D. or other)
Address St. Louis Mo Date signed 12-19-45

(Licensed Embalmer's Statement on Reverse Side)

1193

1193

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 Van M. Szymon

Licensed Embalmer No. 4343

P. O. Address 7415 Zephyr St Inglewood Mi

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.

No. 2B
M—3-45
P I 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.

Registration District No. 3'8 Primary Registration District No. 1003 Registrar's No. 11193

SUPPLEMENTARY

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 Lukes Hosp.
(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 Mo (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 Beatrice Reinert

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 Aug (Month) 9 (Day) 1894 (Year)

8. AGE: Years 57 Months 9 Days 9 If less than one day hr. min.

9. Birthplace (City, town, or county) Ill (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 Dec day 18
year 1945 hour 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 Bant's disease c̄ cirrhosis of liver, jaundice & ascites

Due to Chronic cystitis
Multiple fibroids of uterus

Due to

Other conditions Chronic nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operation 13
Of autopsy as above

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 H. W. Noller (M. D. or other)

Address St Lukes Hosp Date signed 1-28-46

391685