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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 DEC 29 1945

State File No. 42495

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2896

1. PLACE OF DEATH:

(a) County St. Louis County

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

(c) Name of hospital or institution: St. Louis Co. Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether

In this community 32 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 91

(c) City or town University City 3 (If outside city or town limits, write "RURAL")

(d) Street No. 6622 Crest 5 (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Julius Reiter

3. (b) If veteran, name war no

3. (c) Social Security No. 494-03-4432

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Katie Kwitkoski

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased 8 (Month) 25 (Day) 1880 (Year)

8. AGE: Years 65 Months 3 Days 22 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) 4 (State or foreign country)

10. Usual occupation Park Employee

11. Industry or business Laborer

FATHER
12. Name Unknown 2
13. Birthplace Unknown (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 4 (State or foreign country)

16. (a) Informant Son Arthur Reiter 1

(b) Address Clayton & Lindberg

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

(c) Place: burial or cremation Mount Lebanon Cem

18. (a) Signature of funeral director Bannan Bros Inc.

(b) Address 2504 Woodson Rd - Overland, Mo.

19. (a) 12-22-45 (Date received local registrar) (b) E. G. McGowan M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17 year 1945 hour 11 minute 55 P.M.

21. I hereby certify that I attended the deceased from Dec. 15, 1945 to Dec. 17, 1945 that I last saw him alive on Dec. 17, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	4 d.
Due to Arteriosclerosis	
Due to 83 a.l.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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)

(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 Wm. W. Carter M.D. (M. D. or other)

Address 607 Brentwood Clayton Date signed 12-18-45

(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 Oscar. F Mueller

Licensed Embalmer No. 3039

P. O. Address Overland (1X) 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.