

No. 2  
1-5-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

234

FILED FEB 1 1946  
318

State File No. ....

Registration District No. .... Primary Registration District No. ....

Registrar's No. 716

1003

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.  
(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location) Memorial  
(d) Length of stay: In hospital or institution. (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 25  
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17  
(d) Street No. 823 North St (If rural, give location) 9  
(e) Citizen of foreign country? (Yes or No) 10  
If yes, name country

3. (a) PRINT FULL NAME JACK DE REISS

3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

4. Sex MALE / 5. Color or race White  
6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive ..... years  
7. Birth date of deceased April 19 1890  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
55 8 25 hr. min.

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

10. Usual occupation NIGHT CLERK

11. Industry or business

12. Name JACK DE REISS

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

14. Maiden name Unk

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

16. (a) Informant Max Gayer

(b) Address 2231 Millham Pl

17. (a) Quincy, Mo. (b) Date thereof JAN 22 1946  
(Building, crematorium, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CADAVARY

18. (a) Signature of funeral director Carl W. Kell

(b) Address 725 S. Grand St

19. (a) JAN 22 1946 (Date received local registrar) Jo. F. Brebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14th  
year 1946 hour 12:10 minute P M.  
21. I hereby certify that I attended the deceased from 1/7/46  
3 that I last saw him alive on 1/14/46, 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure  
Due to arteriosclerotic Heart Disease  
Due to lung abscess, right middle lobe - Tubercular  
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 13  
Of autopsy

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 0  
23. Signature L. D. Giegay (Physician) 1/14/46  
Address 1515 Lafayette Date signed

Duration  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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**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 A. Lammun*  
.....  
Licensed Embalmer No. *4142*  
.....

P. O. Address.....

**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.**