

No. 2
12-45-
17-39
K47070

FILED NOV 7 1946
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

(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. John's Hospital
(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 **Illinois** (b) County **Perry**

(c) City or town **Pinckneyville**
(If outside city or town limits, write "RURAL") **N.R.**

(d) Street No. _____ (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Matilda Regina Reiniger**

3. (b) If veteran, name war **nil**

3. (c) Social Security No. **318-14-6979**

4. Sex **female**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **Sept. 1st 1896**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	50	1	22	hr. _____ min.

9. Birthplace **Pinckneyville, Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Family nurse**

11. Industry or business _____

12. Name **August Reiniger**

13. Birthplace **Freeburg, Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Deitz**

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

16. (a) Informant **Sylvester Reiniger**

(b) Address **Pinckneyville, Ill.**

17. (a) **removal** (Burial, cremation, or removal) (b) Date thereof **10-24-46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Pinckneyville, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **OCT 25 1946** (Date received local registrar) **J. J. Bredesch** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **23**
year **1946** hour **6** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **Oct. 22nd**
1946, to **Oct. 23rd**, 1946;
that I last saw her alive on **October 23rd**, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death **Measles**
chronic nephritis 1 year.

Due to _____

Due to _____

Other conditions **131-**
(include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **Removal into Kidney & Ureters**

Duration **3 days**

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) (c) Means of injury _____

23. Signature **Raymond Carroll** (M. D. or other)

Address **609 Humboldt Bldg.** Date signed **10-24-**

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.....

John Agnoski

Licensed Embalmer No. *3398*

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.

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:

(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)

3. (a) PRINT FULL NAME Matilda R. Reiniger
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color of race w 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased Sept 21
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace.....
(City, town, or county) (State or foreign country)
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) 10-25-46 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature) 1946

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....
year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
that I last saw him..... above on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

35531