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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38999

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10021

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: 4242 LAFAYETTE AV.
(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 17/7

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 4242 LAFAYETTE AV.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MARLYN-ANN REARICK

3. (b) If veteran, name war NO

3. (c) Social Security No.

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, ~~widowed, married, divorced~~ INFANT

6. (b) Name of husband or wife

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

7. Birth date of deceased JULY (Month) 31 (Day) 1946 (Year)

8. AGE: Years | Months 3 | Days ~~24~~ 23 | If less than one day hr. min.

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

10. Usual occupation INFANT

11. Industry or business

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

MOTHER
14. Maiden name MARCELLA ANDERSON
15. Birthplace HOT SPRINGS (City, town, or county) ARKANSAS (State or foreign country)

16. (a) Informant Mrs Marcella Rearick
(b) Address 4242 Lafayette av

17. (a) BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof 11-25-46 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ CALVARY CEM.

18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette Av.

19. (a) NOV 25 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24
year 1946 hour ~~5~~ minute 30 pm.

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 Bronchio Pneumonia

Due to Primary

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 [signature] (M. D. or other)

Address [signature] Date signed 11/24/46

(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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address St Louis 4 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.