

FILED JAN 3 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 3613

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Crover
(c) Name of hospital or institution: None, Highway #50
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether years, months or days)
In this community 8 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Crover
(If outside city or town limits, write "RURAL")
(d) Street No. Highway #50
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

George G. Reinecke

(b) If veteran, name war none

(c) Social Security No. Unknown

4. Sex Male 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. 13 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 3 0 hr. _____ min.

9. Birthplace # St. Louis Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Fred Reinecke

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hoffman

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Emil Reinecke

(b) Address Chesterfield Mo. R-1.

17. (a) Burial (b) Date thereof Dec. 16-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph Cem. Manchester Mo.

18. (a) Signature of funeral director Schnader Funeral Home

(b) Address Balfour Mo.

19. (a) 12-14-46 (b) Arthur J. Allen M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13
year 1946 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Death without
medical attendance to _____ 19 _____

that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown (Natural Causes) Duration _____

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy No 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? _____

(Specify type of place) _____

(e) Means of injury _____

23. Signature Arthur J. Allen M.D. (M. D. or other) _____

Address 601 Brentwood Blvd.

Date signed 12/16/46

UNWRITING BLACK INK—MAKE A PERMANENT RECORD

2
-43
-39
35697

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Geo. Schrader

Licensed Embalmer No.

P. O. Address.....

*3066
Ballwin, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.