

No. 2  
5-43  
5-17-39  
X36671

FILED JAN 13 1947

Primary Registration District No. 1003

Registrar's No. 11367

1. PLACE OF DEATH:

(a) County MISSOURI

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

(c) Name of hospital or institution:  
STONE NURSING HOME  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 MONTHS  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

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

(d) Street No. 3223 INDIANA  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph (RENNARD) REZNICEK

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 490-03-0712

4. Sex MALE 5. Color or race white

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased DEC. 12 1878  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 31  
year 1946 hour 3 minute P.M.

21. I hereby certify that I attended the deceased from Feb.  
1946 to Dec. 31 1946

that I last saw him alive on Dec. 28 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 68 Months 0 Days 19  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Debilitation  
from  
↓  
Due to Carcinoma of Prostate  
with Metastases to pelvic  
Due to Bones & Lungs.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Shoemaker

11. Industry or business \_\_\_\_\_

12. Name WILLIAM REZNICEK

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

14. Maiden name MARIE NOVAK

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

16. (a) Informant WILLIAM REZNICEK

(b) Address 3223 INDIANA

17. (a) BURIAL (b) Date thereof JAN 3 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OLD S.S. PETER & PAUL

18. (a) Signature of funeral director Thomas Kutis, Jr.

(b) Address 2906 GRAVOIS

19. (a) 1947-2-18 (b) J. F. Bredeck  
(Date received by registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_

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 \_\_\_\_\_

23. Signature Ray Greenbaum (M. D. or other) MD

Address 634 N. Grand Date signed 1-2-47

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

41674

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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.....

Licensed Embalmer No.....

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

Joseph Reznick

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Dec 12 (Month) (Day) (Year)

8. AGE: Years 68 Months..... Days..... If less than one day..... hr..... min.

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

10. Usual occupation newspaper

11. Industry or business.....

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) (Date received local registrar)..... (b) J. F. Prudeck (Registrar's signature)

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..... alive on..... 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)

Major findings: Of operations.....

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) (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER, FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

42865

for - 350