

No. 2
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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

State File No. **15568**
Registrar's No. **3883**

FILED APR 25 1947
318

Registration District No. _____ Primary Registration District No. **100**

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

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:
St. Louis Childrens Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **Maplewood**
(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 _____

3. (a) PRINT FULL NAME **Susan Gertrude Reinbold**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **female** | 5. Color or race **white**

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **Dec. 26 1944**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
2	3	16	hr. _____ min. _____

9. Birthplace **St. Louis** **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Frank Reinbold**

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

14. Maiden name **Esther Stottman**

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

16. (a) Informant **Frank Reinbold**

(b) Address **3317 Cambridge**

17. (a) **burial** (b) Date thereof **Apr. 14, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Pickers Cem.**

18. (a) Signature of funeral director **Jay B. Smith**

(b) Address **7456 Manchester Ave.**

19. (a) **APR 14 1947** (b) **J. B. Beckwith**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **11**
year **47** hour **10** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **4-11** to **4-11**, 19**47**
that I last saw her alive on **4-11**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Meningococemia**
Meningococcus Meningitis

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **6.**

Major findings:
Of operations _____

Of autopsy _____

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 **J. B. Beckwith** (M. D. or other) _____
Address **700 N. Maple** Date signed **4/11**

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 3454

....., Registered Apprentice No.
working under my personal supervision.

Signed David C. Gibbons

Licensed Embalmer No. 3454

P. O. Address 7456 Manchester

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.