No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19272

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4804

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: Josephine Heitkamp Hospital O (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 000
(c) City or town ST. LOUIS 17 (If outside city or town limits, write "RURAL")
(d) Street No. 4148 Castleman Av (If rural, give location)
(e) Citizen of foreign country? 17 (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME NORA SNODGRASS REESE
3. (b) If veteran, name war NO
3. (c) Social Security No.

4. Sex FEMALE
5. Color or race W.
6. (a) ~~Single, widowed~~, married, ~~divorced~~ MARRIED
6. (b) Name of husband or wife GLENN A. REESE
6. (c) Age of husband or wife if alive years
7. Birth date of deceased OCTOBER (Month) 29 (Day) 1915 (Year)

8. AGE: Years 31 Months 6 Days 13 If less than one day hr. min.

9. Birthplace ARKANSAS (City, town, or county) (State or foreign country)
10. Usual occupation HOUSEKEEPER
11. Industry or business OWN
FATHER
12. Name JOSEPH F. GOODWIN
13. Birthplace INDIANA (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name ELLEN BISCHOP
15. Birthplace COLORADO (City, town, or county) (State or foreign country)
16. (a) Informant Mr Glenn A Reese
(b) Address 4148 Castleman av
17. (a) BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof MAY 15 47 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Lakewood Park
18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette av
19. (a) MAY 13 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12 year 1947 hour 8 minute A. M.

21. I hereby certify that I attended the deceased from Oct 10, 1942, to May 12, 1947; that I last saw h alive on May 12, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Surgical shock	3 hrs.
Due to: Post partum hemorrhage	5 hrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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) 0
While at work? (e) Means of injury

23. Signature T. Schindewolf (M.D. or other) M.D.
Address 2026 Ro 89 Date signed 5/12/47

(Licensed Embalmer's Statement on Reverse Side) T. Schindewolf

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 Joe B. Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.