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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED JUL 14 1948
Registration District No. 217

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2156A
Registrar's No. 1586

Primary Registration District No. 3068

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Maplewood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Maplewood Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community 84 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Margaret S. Reitz
3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife Victor Wm. 6. (c) Age of husband or wife if alive - years
7. Birth date of deceased December 15, 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 6 10 hr. min.

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

10. Usual occupation At Home

11. Industry or business -

12. Name Philip Dauernheim

13. Birthplace Hessen-Dorustadt, Germany
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Rathgeber

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

16. (a) Informant Charles H. Reitz

(b) Address 578 Bellsworth Drive, Lemay, Mo.

17. (a) Burial (b) Date thereof 6/26/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS Peter & Paul Cemetery

18. (a) Signature of funeral director BEIDERWIEDEN F.H. INC.

(b) Address 1936 St. Louis Avenue

19. (a) 6-25-48 (b) Paul G. Hays
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2055 Maury Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 25th
year 1948 hour - minute - M.

21. I hereby certify that I attended the deceased from Oct. 4
1935, to June 25, 1948
that I last saw her alive on June 23, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus
Nephritis - Chronic - interstitial
Due to 61

Due to -
Other conditions Sensibility
(Include pregnancy within 3 months of death)
Major findings: Renic poisoning

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 Paul G. Hays M.D. or other MD
Address 506 S. A. GRAVOLS Date signed 6-25-48

1:00 - 4:00 P.M.

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 Paul R. Paulson

Licensed Embalmer No. 4114

P. O. Address 1936 St Louis Ave

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.

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2156445

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town _____
(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 Mrs. Margaret Reitz

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

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

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

7. Birth date of deceased 12 15 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>6</u>	<u>10</u>	_____ hr. _____ min.

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

10. Usual occupation _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 6th day 25th
 year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 10/4/35
 _____, 19____, to 6/25/48, 19____;
 that I last saw her alive on June 23, 1948, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Diabetes meelitus 13 yrs
Nephritis, chronic, parenchymatous ???

Due to Senility
 Due to _____

Other conditions Senility
(Include pregnancy within 3 months of death)
uremic poisoning

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? _____

While at work? _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature Johannes (M. D. or other) _____
 Address 5605 N. TRAVOIS Date signed 6/25/48

PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

2/3

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 the above constitutes grounds for revocation of license.)

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