FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 4 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31575

Registration District No. 317 — Primary Registration District No. 3063 — Registrar's No. 2172

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Louis County Hospital D O A
(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 Missouri (b) County St Louis
(c) City or town Pine Lawn
(If outside city or town limits, write "RURAL")
(d) Street No. 6203 A Bircher
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Charles Louis Reich
3. (b) If veteran, name war Spanish American
3. (c) Social Security No. 49409-8617
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Harriette H Bayliss
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased March 14 1882 (Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace Quincy Illinois (City, town, or county) (State or foreign country)
10. Usual occupation Wood Pattern Maker
11. Industry or business Emerson Electric Co.
FATHER
12. Name Robert Alonzo Reich
13. Birthplace Salisbury N Carolina (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Amelia C Knieper
15. Birthplace Quincy Illinois (City, town, or county) (State or foreign country)
16. (a) Informant Harriette Reich
(b) Address 6203 A Bircher
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/48 (Month) (Day) (Year)
(c) Place: burial or cremation National Cem Jefferson Brks
18. (a) Signature of funeral director Chas J Stuart
(b) Address 1225 Union Blvd
19. (a) 9/5/48 (Date received local registrar) (Registrar's signature) Cecil A G Sharp MD MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4 year 1948 hour 11 minute P M.
21. I hereby certify that I attended the deceased from Died without medical attendance, 19..; that I last saw h..... alive on ....., 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Unknown	
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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 ..... (M. D. or other)
Address Commissioner of Health Date signed 9/14/48

(Licensed Embalmer's Statement on Reverse Side)

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. Albert G. Hopper.

Licensed Embalmer No. 2971

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.

No. 2B
3-45
P I X 43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

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Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2172

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton
(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)

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

3. (a) PRINT FULL NAME Charles L Reich

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 14 (Day) 88 (Year)

8. AGE: Years 66 Months 5 Days 23 If less than one day hr. min

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 4 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death ✓

Unknown deed

Due to

Due to without medical attendance

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

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(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 Cecil A J Sharp (M. D. or other) ✓

Address Commissioner of Health Date signed

SUPPLEMENTARY