No. 300
10-48

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14081

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3798

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Lane Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 1861 S. 13th Street

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): B.
c. (Last): REINKE

4. DATE OF DEATH (Month) (Day) (Year): April 27-1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 20-1880
9. AGE (In years last birthday): 68 — If under 1 year: Months / Days — If under 1 hr.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: John Reinke
13b. MOTHER'S MAIDEN NAME: Matilda Bridsky
14. NAME OF HUSBAND OR WIFE: Agnes Reinke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3/3/49 (5-10 years by history)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Partial bowel obstruction colon.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Ill.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 42/4

22. *I hereby certify that I attended the deceased from* Mar. 3, 1949, *to* April 27, 1949, *that I last saw the deceased alive on* April 26, 1949, *and that death occurred at* 3:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William W. Grundmann MD
23b. ADDRESS: 2519 N. Jefferson St. Louis
23c. DATE SIGNED: 4/28/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Apr. 30-1949
24c. NAME OF CEMETERY OR CREMATORY: Park Lawn
24d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

DATE REC'D BY LOCAL REG.: APR 28 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Mogdell Und.
ADDRESS: 1926 Allen Ave.

(Licensed Embalmer's Statement on Reverse Side)

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

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 Me Student Embalmer No. working under my personal supervision.

Signed Benj. C. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Avenue

Signed ..... Student Embalmer

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.