

FILED DEC 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41810**
Registrar's No. **32**

BIRTH NO. _____ REG. DIST. NO. **233** PRIMARY REG. DIST. NO. **5813**

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

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St Mo	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Upper Louisa c. LENGTH OF STAY (In this place) 2 Yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural-Wolfsville Mo		d. STREET ADDRESS (If rural, give location) 1832 N 22nd St	

3. NAME OF DECEASED (Type or Print) a. (First) FRANK	b. (Middle) *****	c. (Last) REISBECK	4. DATE OF DEATH (Month) (Day) (Year) Dec 19-1949
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5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec-22-1872	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 11 Days 27	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver	10b. KIND OF BUSINESS OR INDUSTRY Brewery	11. BIRTHPLACE (State or foreign country) Bellville Ill	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Dont know	13b. MOTHER'S MAIDEN NAME Dont know	14. NAME OF HUSBAND OR WIFE Roxie Reisbeck
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 492-01-5362	17. INFORMANT'S SIGNATURE OR NAME Mrs Roxie Reisbeck ADDRESS Bellville Mo
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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		INTERVAL BETWEEN ONSET AND DEATH 20 year
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerosis		
	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.		4500	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **July**, 1949, to **Dec 19**, 1949, that I last saw the deceased alive on **Dec 19**, 1949, and that death occurred at **8:00** p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. H. Walker M.D.	23b. ADDRESS Waller Mo	23c. DATE SIGNED 12/19/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 23 1949	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) St Louis Mo
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DATE REC'D BY LOCAL REG. 12/22/49	REGISTRAR'S SIGNATURE W. S. Roman	25. FUNERAL DIRECTOR'S SIGNATURE W. B. Wells ADDRESS Waller Mo
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District File Number _____
District Health Officer No. 9,
RECEIVED
DEC 27 1949

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, _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed F. B. Hulls

Licensed Embalmer No. 1588

P. O. Address Hullsville, Mo.

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.