

FILED APR 20 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

14904

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3269**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2139	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5400 Arsenal St.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis State Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) REHM c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) April 6 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH August 4, 1883
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver, Ret.	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Rehm	
13b. MOTHER'S MAIDEN NAME Emma Plitt		14. NAME OF HUSBAND OR WIFE Lee Rehm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. 489-07-3543	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Elsie Ballman 8231 Paramount			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia-entire right lung INTERVAL BETWEEN ONSET AND DEATH 5 days 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.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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) 490X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-1- 19 40 to April 6, 19 50 , that I last saw the deceased alive on April 6, 1950 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.			
23a. SIGNATURE L. Hoppe, M.D. (Degree or title)		23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 4/6/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-8-50	24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
DATE SIGNED BY LOCAL REGISTRAR'S SIGNATURE APR 7 1950 J.B. Sauter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington		

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.

Student
Student Embalmer

Signed: W. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis 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.