V.S. No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34411

BIRTH NO. _____ REG. DIST. NO. 52 PRIMARY REG. DIST. NO. 5281 Registrar's No. 62

1. PLACE OF DEATH
a. COUNTY: Cape Girardeau
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Freidheime
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): Bruenie Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: Cape Gir
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Wells Mo 0160
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Herman
b. (Middle):
c. (Last): Reisenbichler

4. DATE OF DEATH (Month) (Day) (Year): Nov 5 1952

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec 15 1873
9. AGE (In years last birthday): 79 — If under 1 year: Months: Days: 10 20 — If under 1 day: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Labor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): New Wells Mo
12. CITIZEN OF WHAT COUNTRY?: U S A

13a. FATHER'S NAME: Herman Reisenbichler
13b. MOTHER'S MAIDEN NAME: Mary Schupfer
14. NAME OF HUSBAND OR WIFE: Single

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.: None
17. INFORMANT'S SIGNATURE OR NAME: Aug Reisenbichler
ADDRESS: Pocohontas Mo

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): Cholelitis of the Liver — INTERVAL BETWEEN ONSET AND DEATH:

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: 583X
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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-27, 1952, *to* 11-4, 1952, *that I last saw the deceased alive on* 11-4, 1952, *and that death occurred at* 6 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. D. Blaylock M.D. (Degree or title)
23b. ADDRESS: Oak Ridge Mo
23c. DATE SIGNED: 11-6-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 8 1952
24c. NAME OF CEMETERY OR CREMATORY: New Wells Cemetery
24d. LOCATION (City, town, or county) (State): New Wells MO

DATE REC'D BY LOCAL REG.: Nov 7-52
REGISTRAR'S SIGNATURE: D. G. Sutton 43-0
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: McCombs Funeral Co Jackson Mo

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 10 1953

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 _____, Student Embalmer No. _____, working under my personal supervision.

Student .....
Student Embalmer

Signed B. A. Meyer

Licensed Embalmer No. 3057

P. O. Address Jackson 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.