

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **7873**
Registrar's No. **1415**

FILED FEB 26 1953

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1415		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri			c. LENGTH OF STAY (In this place) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2099					
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				d. STREET ADDRESS (If rural, give location) 1927 E College Ave				
3. NAME OF DECEASED (Type or Print) MINNIE		a. (First)		b. (Middle)		c. (Last) REAKER		
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S		8. DATE OF BIRTH 11-9-1869		
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months		IF UNDER 1 Mth. Days		4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 4, 1953		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (City and State or Foreign Country) St Louis MO		12. CITIZEN OF WHAT COUNTRY? yes	
13a. FATHER'S NAME Frederick Reker			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Charance J Reker ADDRESS 4232 Linton				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma Renal pelvis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (a.e., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21f. HOW DID INJURY OCCUR? 180X		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from 2-3-53 , 19____, to 2-4-53 , 19____, that I last saw the deceased alive on 2-4-53 , 19____, and that death occurred at 11:20 AM. , from the causes and on the date stated above.				
23a. SIGNATURE J. Donald Ferry MD (Degree or title)			23b. ADDRESS 1515 Lafayette Avenue			23c. DATE SIGNED 2-5-53		
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 2/7/52		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St Louis County		
DATE REC'D BY LOCAL REG. FEB 6 1953		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Central St. ADDRESS 5041 Bevern				

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 *Ben E. Hoffman*

Licensed Embalmer No. 4366

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.