No. 300
10.48

FEB 26 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7878

State File No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1552

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): DePaul Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Madison 8120
d. STREET ADDRESS (If rural, give location): Bend Road 8

3. NAME OF DECEASED (Type or Print)
a. (First): Selina
b. (Middle): M.
c. (Last): Reiske

4. DATE OF DEATH (Month) (Day) (Year): Feb. 7 1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 18, 1877
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

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

13a. FATHER'S NAME: John Wein
13b. MOTHER'S MAIDEN NAME: Mary Romann
14. NAME OF HUSBAND OR WIFE:

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: John Reiske — **ADDRESS**: Bend Road Madison, Ill.

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): Cancer of Cecum — 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.*: Myocardial failure

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Cancer of Cecum
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?: 153 X

22. *I hereby certify that I attended the deceased from* 1-23-, 1953 *to* 2-17-, 1953 *that I last saw the deceased alive on* 2-17-, 1953, *and that death occurred at* 4:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. T. Thompson (Degree or title): M.D.
23b. ADDRESS: 4952 Maryland
23c. DATE SIGNED: 2-9-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 2-7-1953
24c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery
24d. LOCATION (City, town, or county) (State): Granite City, Illinois

DATE REC'D BY LOCAL REG.: FEB 9 1953
REGISTRAR'S SIGNATURE: H. Carl Smith M.D. MRB
25. FUNERAL DIRECTOR'S SIGNATURE: Frank Mercer — **ADDRESS**: Granite City Ill.
(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 ..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Charles E. Mercer

Licensed Embalmer No. 2988

P. O. Address Granite City

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.