

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12211

FILED MAR 31 1953

State File No. \_\_\_\_\_  
Registrar's No. 2830

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|  |                    |   |   |  |  |  |                          |   |                        |
|--|--------------------|---|---|--|--|--|--------------------------|---|------------------------|
| BIRTH NO. _____  |                    | REG. DIST. NO. _____  |   | PRIMARY REG. DIST. NO. _____   |  | State File No. _____   |                          | Registrar's No. 2830  |                        |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                    |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY _____ |  |  |                          |   |                        |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN St. Louis  |                    | c. LENGTH OF STAY (In this place)<br>Life   |   | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN St. Louis                                  |  | 2159   |                          |   |                        |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital   |                    |   |   | d. STREET ADDRESS (If rural, give location)<br>15 3654 Lierman Avenue  |  | 0  |                          |   |                        |
| 3. NAME OF DECEASED (Type or Print) a. (First) REX   |                    | b. (Middle) RAYMOND   |   | c. (Last) REINHARDT  |  | 4. DATE OF DEATH (Month) (Day) (Year) March 15, 1953                     |                          |   |                        |
| 5. SEX M   | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S  |   | 8. DATE OF BIRTH July 7, 1951  |  | 9. AGE (In years last birthday) 1  | IF UNDER 1 YEAR Months 8 | IF UNDER 24 HRS. Days 8   | IF UNDER 24 HRS. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant   |                    |   | 10b. KIND OF BUSINESS OR INDUSTRY _____ |  | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri           |  |                          | 12. CITIZEN OF WHAT COUNTRY? _____                                    |                        |
| 13a. FATHER'S NAME Eura John Reinhardt   |                    |   | 13b. MOTHER'S MAIDEN NAME Hilda Reiter  |  |  | 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 ADDRESS E.J. Reinhardt 3654 Lierman Avenue   |  |  |                          |   |                        |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |                    | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Meningocele<br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |  |  |  |                          | INTERVAL BETWEEN ONSET AND DEATH<br><br>Surrendered                   |                        |
| 19a. DATE OF OPERATION 2/28/53   |                    | 19b. MAJOR FINDINGS OF OPERATION Hydrocephalus -  |   |  |  |  |                          | 20. AUTOPSY? YES <input 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) _____  |  | 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? 751X   |   |  |  |  |                          |   |                        |
| 22. I hereby certify that I attended the deceased from 7/7, 1951, to 3/15, 1953, that I last saw the deceased alive on 2/14, 1953 and that death occurred at 2:45 a.m., from the causes and on the date stated above.        |                    |   |   |  |  |  |                          |   |                        |
| 23a. SIGNATURE (Degree or title) E. J. Reinhardt M.D.  |                    |   |   | 23b. ADDRESS Beaumont Ind Bldg   |  |  | 23c. DATE SIGNED 3/15/53 |   |                        |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal  |                    | 24b. DATE 3-16-53   |   | 24c. NAME OF CEMETERY OR CREMATORY Laurel Hills Mem. Garden  |  | 24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |                          |   |                        |
| DATE REC'D BY LOCAL REG. MAR 16 1953   |                    | REGISTRAR'S SIGNATURE J. Earl Smith M.D.  |   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beiderwieden F.H. 1936 St. Louis Avenue |  |                          |   |                        |

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 \_\_\_\_\_

*none*

Student Embalmer No. *none*

working under my personal supervision.

Student *none*  
Student Embalmer

Signed *Julius J. Krepin*  
Licensed Embalmer No. *3497*

P. O. Address *St. Louis*

**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.