

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28072**
Registrar's No. **7086**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY 4111 Loughboro St. Louis				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 town) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4111 Loughborough				e. STREET ADDRESS (If rural, give location) 4111 Loughborough 20190			
3. NAME OF DECEASED (Type or Print) a. (First) Joseph J. Rechten b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) Aug. 12, 1955				
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 28, 1878	
9. AGE (In years last birthday) 76		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) retired 10 yrs.		10b. KIND OF BUSINESS OR INDUSTRY laborer		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Bennick Rechten			13b. MOTHER'S MAIDEN NAME Elizabeth Ruschenberg			14. NAME OF HUSBAND OR WIFE Clara Rechten	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Rechten 4111 Loughborough			
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) myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cholelithiasis					INTERVAL BETWEEN ONSET AND DEATH 10-1549 ?
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION none				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 _____			
22. I hereby certify that I attended the deceased from 8/12, 1955 , to 8/12/55 , 19____, that I last saw the deceased alive on 8/12, 1955 , and that death occurred at 10:45 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE Edna W. ...				23b. ADDRESS 740 So 4		23c. DATE SIGNED 8/13/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 8-16-55		24c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. AUG 13 1955		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Southern Funeral Home 6322 S. Grand Blv., St. Louis, Mo.			

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

DR. GLENN NORTHUP
740 S. 4th ST.
GA 1-1923

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. *424*

P. O. Address *579 Lewis St*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.