

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42534**  
Registrar's No. **11027**

FILED JAN 6 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS Mo</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>210 SIDNEY</b>		e. STREET ADDRESS (If rural, give location) <b>23 210 SIDNEY</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>FRANK J.</b> b. (Middle) <b>REININGER</b> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>DEC. 15 1955</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB. 13 1886</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>RICHARDSON DRUG</b>	11. BIRTHPLACE (City and State or foreign Country) <b>ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>FRANK REININGER</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>CLARA REININGER</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>CLARA REININGER</b> ADDRESS <b>210 SIDNEY</b>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>SARCOMA - LUNG</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>SARCOMA - MUSCLES OF BACK</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>RM</b>			

19a. DATE OF OPERATION <b>1953</b>	19b. MAJOR FINDINGS OF OPERATION <b>SARCOMA</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) <b>SUICIDE</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from **JAN 1, 1953**, to **DEC 17, 1955**, that I last saw the deceased alive on **DEC 17, 1955**, and that death occurred at **11 a** m., from the causes and on the date stated above.

23a. SIGNATURE <b>O. J. McNamee</b> (Degree or title) <b>MD</b>	23b. ADDRESS <b>7619 Ivory</b>	23c. DATE SIGNED <b>Dec 18, 1955</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	24b. DATE <b>DEC. 17 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>
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DATE REC'D BY LOCAL REG. <b>DEC 16 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Kuto 2906</b> ADDRESS <b>St Louis</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Physician states: Sarcoma lung-secondary; primary in back

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

*Leo J. Budde*

Licensed Embalmer No. 39

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.