

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 21 1956

State File No. **32357**
Registrar's No. **7882**

318

PRIMARY REG. DIST. NO. 1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Missouri				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 township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 1 Month		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Chronic Hospital				e. STREET ADDRESS (If rural, give location) 21390 5600 Arsenal			
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) _____		c. (Last) Reichman		4. DATE OF DEATH (Month) (Day) (Year) 8/25/56	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower		8. DATE OF BIRTH 2/5/91	
9. AGE (In years last birthday) 65		if UNDER 1 YEAR Months _____ Days _____		if UNDER 1 Hrs. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles Reichman		13b. MOTHER'S MAIDEN NAME Christina		14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Chronic Hospital, 5600 Arsenal			
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) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) 332X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cancer of Liver Arteriosclerotic Head Disease				INTERVAL BETWEEN ONSET AND DEATH 3 days	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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 7/25, 1956 to 8/25, 1956 , that I last saw the deceased alive on 8/25 1956 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
23a. SIGNATURE George M. Janak, M.D. (Degree or title)				23b. ADDRESS 5600 Arsenal Street		23c. DATE SIGNED 8/25/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug. 28, 1956		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		24d. LOCATION (City, town, or county) (State) 7901 Gravois ave.	
DATE REC'D BY LOCAL REG. AUG 27 1956		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U. & L. Co. 7814 S. Broadway			

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.....
Signature of Student Embalmer

Signed *Louis C. Hoffmann*.....

Licensed Embalmer No. *3871*.....

P. O. Address *7814 S. Broadway*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.