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FILED FEB 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3023
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 544

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: 915 N.Grand,St.Louis,Mo. Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VET. ADM. HOSPITAL Length of stay in Hospital or Institution: 71 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: ~~ST LOUIS~~
c. CITY OR TOWN: ST. LOUIS Inside Limits Yes X No ☐
STREET ADDRESS (If outside, give location): 1169 CANAAN AVENUE Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First EUGENE Middle — Last REAHR
4. DATE OF DEATH: Month 1 Day 17 Year 57
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-11-11
9. AGE (In years last birthday): 45
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): MACHINE OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): ST. LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: FRANK REAHR
14. MOTHER'S MAIDEN NAME: MARY KERRUISH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-2
16. SOCIAL SECURITY NO.: 498-18-8094 UNKNOWN
17. INFORMANT Address: VA HOSP.RECORDS,915 N.GRAND,ST.LOUIS, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CHRONIC MYELOGENOUS LEUKEMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 204.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Right lower lobe pneumonia
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. VA attended the deceased from 11-7-56 to 1-17-57 and last saw him alive on 1-17-57
Death occurred at 1:35 PM m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: M D Gallagher (Degree or title) M.D.
22b. ADDRESS: 915 N.Grand VA Hosp. St.Louis, Mo.
22c. DATE SIGNED: 1-17-57
23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 1-21-57
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barracks,Mo.
24. FUNERAL DIRECTOR ADDRESS: JOHN STYGAR & SON — 5541 RIVERVIEW BLVD.
25. DATE REC'D. BY LOCAL REG.: JAN 18 '57
26. REGISTRAR'S SIGNATURE: J Earl Smith MD M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 39

P. O. Address.....

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