

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15185

FILED MAY - 8 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4010**

Health,
Welfare
Public
Service

300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hosp		d. STREET ADDRESS (If inside, give location) 5954 TARA LANE	
3. NAME OF DECEASED (Type or print) Harry J. Rehage		4. DATE OF DEATH 4-24-57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-1888
9. AGE (In years last birthday) 68		10. KIND OF BUSINESS OR INDUSTRY Retired Freight Solicitor R.R. & Trucking	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edw C Rehage		14. MOTHER'S MAIDEN NAME Eliz Sieling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Lorena Rehage		Address 5954 Tara Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Thyrotoxic Crisis DUE TO (b) Thyrotoxicosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 252.0			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from FEB. 9, 1957 to April 24, 1957 and last saw her him alive on 4-24-57 Death occurred at 4:10 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
SIGNATURE (Degree or title) Doctor J. Kutryk, M.D.		22b. ADDRESS 6000 W. Florsheim	22c. DATE SIGNED 4/26/57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-27-57	23c. NAME OF CEMETERY OR CREMATORY St. Peter's	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo
24. FUNERAL DIRECTOR A. Kloss	ADDRESS 2707 N. Grand	25. DATE RECD. BY LOCAL REG. APR 26 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith MO

(Licensed Embalmer's Statement on Reverse Side)

securing the medical certificate on reverse side

8001

312

1919

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 *Loren E. Percy*.....
Licensed Embalmer No. 409

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.