Health, Welfare Public Service

300 -57

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-012202
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2775

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Louis — Inside Limits: Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 01 3640 Oregon — Length of stay in 1b: 75 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY

c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location): 24 0 3640 Oregon — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: William Middle: G Last: Reinke

4. DATE OF DEATH: Month: March Day: 7, Year: 1958

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: October 16, 1872

9. AGE (In years last birthday): 85 — 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): Mfgr.&Repairer

10b. KIND OF BUSINESS OR INDUSTRY: of Surgical Instruments

11. BIRTHPLACE (City and state or country): Hamburg, Germany 4

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: John Reinke

13b. MOTHER'S MAIDEN NAME: Emelie Brietzke

14. NAME OF HUSBAND OR WIFE: Amanda Kraft Reinke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Amanda Reinke Address: 3640 Oregon

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): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Infirmities of age and — 6 mo.
DUE TO (c): Malnutrition

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 434.4

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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. I attended the deceased from May - 1941, to March 7 and last saw her/him alive on March 7, 1958
Death occurred at 2:15 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): D. F. Johnson M.D. 0

22b. ADDRESS: 6400 Morganford

22c. DATE SIGNED: 3-7-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3/10/58

23c. NAME OF CEMETERY OR CREMATORY: New St. Marcus Cemetery

23d. LOCATION (City, town, or county): St. Louis (State): Missouri

24. FUNERAL DIRECTOR: Beiderwieden F.H.Inc. ADDRESS: 1936 St.Louis

25. DATE RECD. BY LOCAL REG.: MAR 10 '58

26. REGISTRAR'S SIGNATURE: J Carl Smith MD MJB.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Hm 1-48

2.30-5 1.8

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. 4520

P. O. Address .....

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.