

Health, Welfare, Public Service

FILED MAR 17 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012766
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 649

300
1-57
Dr. Walters 3608 S. Grand
RN-2-7-89

1. PLACE OF DEATH a. COUNTY St. Louis			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 Gardenville		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis 2199		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Miller Nursing Home		Length of stay in lb 5 wks.	d. STREET ADDRESS (If outside, give location) 4634 Blaine Ave		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle E. Last REICHMAN			4. DATE OF DEATH 3-2-1958		
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 9-12-1884		9. AGE (In years last birthday) 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Terminal R.R.	11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Reichman		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE None	
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. 702-12-5638		17. INFORMANT John Reichman Address 4625 Delor St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Left Side Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arterio sclerosis DUE TO (c) 331X					INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) 2		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 Nov-1-57 3/2/58 and last saw her alive on 3/1/58 Death occurred at 11:30A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE wf Walters (Degree or title) MD			22b. ADDRESS 3608 S Grand St		22c. DATE SIGNED 3/3/58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-5-1958	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) Lillian and Lucas Hunt Rds Mo
24. FUNERAL DIRECTOR Ziegler & Bar ADDRESS 6409 Gravois Ave		25. DATE RECD. BY LOCAL REG. 3-3-58		26. REGISTRAR'S SIGNATURE Herbert P. Donke M.D.	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

STATE OF MISSOURI
 DEPARTMENT OF HEALTH
 BUREAU OF HEALTH OFFICERS
 ST. LOUIS, MISSOURI

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 *John M. Seymour*

Licensed Embalmer No. *4343*

P. O. Address *St. Louis, Mo.*

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.