

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020901

STATE FILE NUMBER

FILED JUL 7 1958 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 290

300  
-57

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) Columbia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fredericktown <sup>0620</sup> <sub>0</sub>
c. FULL NAME OF HOSPITAL OR INSTITUTION Missouri State Cancer Hospital		Length of stay in 1b 70 days	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) Annie Lillian Reinbold	4. DATE OF DEATH Month 7 Day 2 Year 1958
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-91	9. AGE (In years last birthday) 66	10. FUNDING YEAR	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office work	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Madison County - Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Josiah M. White	13b. MOTHER'S MAIDEN NAME Jessie Newcum	14. NAME OF HUSBAND OR WIFE Samuel Reinbold
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 492-05-1216	17. INFORMANT Address Hospital Records - Highway 40, Columbia, Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small Bowel Fistula	INTERVAL BETWEEN ONSET AND DEATH 1 month
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) IRRADIATION effect - small Bowel 3 mos

DUE TO (c) Adenocarcinoma - uterus (endometrium) 172x

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY . Hour Month, Day, Year a.m. p.m.
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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
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21. I attended the deceased from 4-2-58 to 7-2-58 and last saw her alive on 7-2-58 Death occurred at 5:40 P. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE E J Schewe (Degree or title) MD	22b. ADDRESS State Cancer Hosp	22c. DATE SIGNED 7-2-58
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7/5/58	23c. NAME OF CEMETERY OR CREMATORY Oak Hill	23d. LOCATION (City, town, or county) (State) Fredericktown, Mo
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24. FUNERAL DIRECTOR [Signature] ADDRESS [Address]	25. DATE RECD. BY LOCAL REG. July 3 1958	26. REGISTRAR'S SIGNATURE Mrs. R.E. Palmer
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUL 16 1958

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 *James D. ...*

Licensed Embalmer No. *4425*

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.