

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023661  
STATE FILE NUMBER

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

FILED JUN 27 1958		Registration District No. 318		Primary Registration District No. 1003		Registrar's 6045	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY St. Louis		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Arkansas		b. COUNTY Mississippi	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		Length of stay in 1b 5 days		c. CITY OR TOWN Blytheville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Base	
First WALTER		Middle		Last REINIG		Month Day Year June 11, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 13, 1937		9. AGE (In years last birthday) 21		IF UNDER 1 YEAR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weapons Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Air Force		11. BIRTHPLACE (City and state or country) Steuben Co., Indiana /		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter J. F. Reinig				14. MOTHER'S MAIDEN NAME Dehea V. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 309-36-9808		17. INFORMANT Mrs. Dehea Reinig, Rt. 1, Waterloo, Indiana			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Lower Nephron Nephrosis; DUE TO (c) Ruptured Spleen & Ruptured Left Kidney					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. PLACE OF OCCURRENCE (Enter street, office, etc., if applicable) vicinity of Mount Carmel, Ill.					18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour Month, Day, Year 6:22 p.m. 5 31 58		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) 32 Highway					18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) 32 Highway		20f. CITY, TOWN, OR LOCATION near Mount Carmel, Ill.					18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I attended the deceased from 800 P. to and last saw her alive on							18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE (Name or title) [Signature]							22c. DATE SIGNED 6/12/58
23a. FORMAL PREPARATION REMOVAL (Specify) Removal		23b. DATE 6/12/58		23c. NAME OF CEMETERY OR CREMATORY Local Cemetery		23d. LOCATION (City, town, or county) Hamilton, Indiana	
24. FUNERAL DIRECTOR P. W. Schildknecht O'Fallon, Illinois			25. DATE RECD. BY LOCAL REG. JUN 12 58		26. REGISTRAR'S SIGNATURE [Signature]		

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 *Frank Proloff* .....  
Licensed Embalmer No. *43* .....  
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.