

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031385  
STATE FILE NUMBER

FILED SEP 12 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2229

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		c. CITY OR TOWN <b>4170 NORMANDY 0</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7639 Forest View Drive YRS</b>		d. STREET ADDRESS (If outside, give location) <b>7639 FOREST VIEW</b>	
Length of stay in 1b <b>YRS</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>CAROLINE</b> Middle <b>J.</b> Last <b>REIN</b>			4. DATE OF DEATH Month <b>August</b> Day <b>25th</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-24-1884</b>	9. AGE (In years last birthday) <b>74</b>	FUNDER 1 YEAR Months Days Hours Min.	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) <b>HOUSEWORK.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and state or country) <b>ST LOUIS MO 0</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>FRED J. REIN</b>	13b. MOTHER'S MAIDEN NAME <b>JOHANNA E. KREBS</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>UNK.</b>	17. INFORMANT Address <b>MRS RALPH S. DUKE 829 WARDEN</b>
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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) <b>coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerosis heart disease</b>	<b>5 years.</b>
	DUE TO (c) <b>4200</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from <b>Dec. 29, 1952</b> to <b>Aug. 25, 1958</b> and last saw her alive on <b>Aug. 25, 1958</b> Death occurred at <b>1:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>William H. Greenmann M.D.</b>	(Degree or title)	22b. ADDRESS <b>634 North Grand Avenue</b>	22c. DATE SIGNED <b>8/25/1958</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8/28/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>VALHALLA</b>	23d. LOCATION (City, town, or county) (State) <b>ST LOUIS Co. MO</b>
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24. FUNERAL DIRECTOR <b>C.R. Lupton &amp; Sons</b>	ADDRESS <b>7233 DELMAR</b>	25. DATE RECD. BY LOCAL REG. <b>8-26-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

634 North Grand  
Jefferson 3-4000  
Hours: Before 4 PM Mon.  
1:30 to 4 P.M. Tues.

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*  
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.