Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007569

STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1733

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) Chronic Hosp. — Length of stay in 1b 13 days

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

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

d. STREET ADDRESS 3458a Oregon (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Lillie Middle Louisa Last Rheine

4. DATE OF DEATH Month Day Year 2-17-59

5. SEX female

6. COLOR OR RACE white

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

8. DATE OF BIRTH Feb. 17, 1883

9. AGE (In years last birthday) 76 yrs — 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) Housework

10b. KIND OF BUSINESS OR INDUSTRY Domestic

11. BIRTHPLACE (City and state or country) Mo. St. Louis

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME August Rheine

13b. MOTHER'S MAIDEN NAME Margaret Lakor

14. NAME OF HUSBAND OR WIFE ----------

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

16. SOCIAL SECURITY NO. 487-36-6013

17. INFORMANT Miss Anna Rheine, Address 3458a Oregon Ave. 18

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Left Lower Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 mk

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____

DUE TO (c) 490 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis - 2 mks.

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

20a. ACCIDENT [X] 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 2-4-59, to 2-17-59 and last saw her/him alive on 2-17-59

Death occurred at 8:55 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.

22b. ADDRESS 5800 Arsenal

22c. DATE SIGNED 2/17/59

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

23b. DATE Feb.19,1959

23c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery

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

24. FUNERAL DIRECTOR ADDRESS CALVIN F.FEUTZ, 4828 NAT'L.BRIDGE BLVD.

25. DATE RECD. BY LOCAL REG. FEB 18 '59

26. REGISTRAR'S SIGNATURE Karl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Ralph T. Lindsey

Licensed Embalmer No. 4275

P. O. Address St. Louis 7

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.