

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018741

STATE FILE NUMBER

FILED MAY 21 1959

Registration District No.

290

Primary Registration District No.

Registrar's No.

57

5. 300
1-57

1. PLACE OF DEATH a. COUNTY Pulaski				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wisconsin b. COUNTY Milwaukee				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Milwaukee		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Range # 10			Length of stay in lb		848 ^d STREET ADDRESS 109 E Plainfield Ave		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Michael Last Rehorst				4. DATE OF DEATH Month May Day 13 Year 1959				
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 22 Jan 1939		9. AGE (In years last birthday) 20	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) Student			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Milwaukee, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Deceased			13b. MOTHER'S MAIDEN NAME Beulah Annabelle Heiderich			14. NAME OF HUSBAND OR WIFE -		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes Mar 17, 1952 to Pres. 397-36-0805			16. SOCIAL SECURITY NO. Pres. 397-36-0805		17. INFORMANT Address Bernard S Wysocki, US Army Hosp, Ft Wood, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decapitation							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Blast Injury, Hand Grenade							9198	
DUE TO (c)							43	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) Exploding Hand Grenade					
20c. TIME OF INJURY Hour 11:00 a.m. Month, Day, Year May 13, 59			20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Range # 10			20f. CITY, TOWN, OR LOCATION Fort Leonard Wood		COUNTY Pulaski		STATE Missouri	
21. I signed the deceased on 13 May, 1959 , to xxxxxxxxxxxxxx Death occurred at 11:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Hans H. Baruch, Capt, MC					22b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri		22c. DATE SIGNED 13 May 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE May 15 1959		23c. NAME OF CEMETERY OR CREMATORY Unknown Milwaukee Wisc.		23d. LOCATION (City, town, or county) (State) Milwaukee Wisconsin	
24. FUNERAL DIRECTOR Hedges ADDRESS HEDGES FUNERAL HOMES INC CROCKER MO				25. DATE RECD. BY LOCAL REG. 5-15-59		26. REGISTRAR'S SIGNATURE Emilia Grace Anderson		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

MAY 28 1959

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 *Clarence Thion*

Licensed Embalmer No. *4896*
P. O. Address *Waynesville, N.C.*

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.