

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 27 1959

59-030723

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7509** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		a. STATE <i>Mo.</i>	b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1810 Michigan</i>		c. CITY OR TOWN <i>St. Louis</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <i>1810 Michigan</i>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Louis</i> Middle <i>R. Reifschneider</i> Last			4. DATE OF DEATH Month <i>Aug.</i> Day <i>10</i> Year <i>1959</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 10 1897</i>	9. AGE (last birthday) <i>62</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	

13. FATHER'S NAME <i>Louis R. Reifschneider</i>		13b. MOTHER'S MAIDEN NAME <i>Sophy Darian</i>		14. NAME OF HUSBAND OR WIFE <i>Frances R.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. F. Reifschneider, 1810 Michigan</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <i>15 mos</i>
IMMEDIATE CAUSE (a) <i>Carcinoma of Pharynx</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b)			
DUE TO (c) <i>148x</i>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)	
20c. TIME OF INJURY Hour <i>9</i> a.m. p.m.	Month, Day, Year		
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

21. I attended the deceased from *1957* to *1959* and last saw ^{her}him alive on *Aug 3 1959*
Death occurred at *9* *p.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

21. SIGNATURE (Degree or title) <i>Paul C. Hagemann M.D.</i>		22b. ADDRESS <i>3720 Washington</i>		22c. DATE SIGNED <i>8/11/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Aug 13 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Manchester Mo.</i>

24. FUNERAL DIRECTOR <i>Joe A. Howard 1619 So. Grand</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 12 '59</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Lawrence O. Hunt

Licensed Embalmer No. 4979

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.