

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037990

FILED VS. NOV. 6, 1959

2 9969

STATE FILE NUMBER

UNDECEASED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 10 hrs.		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5121 S Compton		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HERMAN Last REICH				4. DATE OF DEATH Month Oct. Day 28 Year 1959				
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/20/87	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) St. Genevieve Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Joseph Reich			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Emma Reich		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Emma Reich		Address 5121 S. Compton		
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		
IMMEDIATE CAUSE (a) Cardiac failure						12 hr		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) Post Cardio Vas accident syndrome 8 mo		
DUE TO (c) Malnutrition						1 mo		
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		
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 _____ 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 10-14-58 to 10-28-59 and last saw her/him alive on 10-28-59 Death occurred at 6:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) J. H. Tuttleman M.D.				22b. ADDRESS 5600 S Compton			22c. DATE SIGNED 10-30-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/31/59		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) Lemay Mo.		(State)
24. FUNERAL DIRECTOR Fendler Und. Co. 7420 Michigan				25. DATE RECD. BY LOCAL REG. OCT 30 1959		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

Dr Edward Wirthlin
5700 S. Compton Fl 1-3383
9-14-30 Fin.

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Me

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.