

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-017262
STATE FILE NUMBER

FILED VS APR 29 1960

2 4079

ENDED

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Clayton
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7529 Wellington Way
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First J.	Middle BEN	Last REICHMAN	4. DATE OF DEATH	Month April	Day 12th	Year 1960
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/14/92	9. AGE (last birthday) 67	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exe. - J.B. Reichman Co.	10b. KIND OF BUSINESS OR INDUSTRY Button & Label	11. BIRTHPLACE (City and state or country) New York	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME David Reichman	13b. MOTHER'S MAIDEN NAME Minnie Spettner	14. NAME OF HUSBAND OR WIFE Hylda G. Reichman
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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) Unk.	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Mrs. J.B. Reichman-7529 Wellington Way
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Ventricular Fibrillation	2 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	?
	DUE TO (c) 420.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cardiac failure	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.)
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20c. TIME OF INJURY	Hour	Month, Day, Year
	a.m. p.m.	

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
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21. I attended the deceased from 1950 to 1960 and last saw her/him alive on 4-3-60
Death occurred at 4:30 PM. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Melvin B. Kravitz MD	22b. ADDRESS 950 Francis Pl.	22c. DATE SIGNED 4-13-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/14/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Missouri
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24. FUNERAL DIRECTOR Herman Rindskopf Inc. 5216 Delmar	25. DATE RECD. BY LOCAL REG. APR 14 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

State of New York

Department of Health

Division of Health

Office of the State Health Officer

State Health Officer

Albany, New York

January 1, 1950

1950

1950

of the

State

of New York

State

Department of Health

Division of Health

Office of the State Health Officer

State Health Officer

Division of Health

BY

John Ketter, State Health Officer

Signature

Date

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

John Ketter

Licensed Embalmer No. 3880

P. O. Address _____

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.