

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031415

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2167

AMENDED

FILED SEP 1 1961

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Affton, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>WEEKS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>8005 Gravors Henninger Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>3707a McDonald</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Clara M. Reinhard</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1961</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9 1876</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Adolph Zeibig</u>		13b. MOTHER'S MAIDEN NAME <u>Margaretha Lahm</u>	
14. NAME OF HUSBAND OR WIFE <u>Louis M. Reinhard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Louis M. Reinhard</u>		Address <u>3707a McDonald</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
DUE TO (b) <u>A. S. H. D.</u>		
DUE TO (c) <u>420.0</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile psychosis due to cerebral arteriosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>2 a.m.</u> 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 <u>Ward 4, 1961</u> to <u>Aug 1, 1961</u> and last saw her alive on <u>July 31, 1961</u>	COUNTY	STATE
21. I attended the deceased from Death occurred at <u>2 a.m.</u> on <u>Aug 1, 1961</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Joseph C. Crowell M.D.</u>	(Degree or title)	22b. ADDRESS <u>9764 Tesson Ferry Rd</u>	22c. DATE SIGNED <u>8/1/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	23b. DATE <u>8-3-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope Mausoleum</u>	23d. LOCATION (City, town, or county) (State) <u>Lemay, Mo.</u>

24. FUNERAL DIRECTOR <u>Southern Funeral Home</u> <u>6322 S. Grand, St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-1-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

Dr Hugh. Crowell
9764 Tesson Ferry
Jul 2-0648

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 Hugh J. Crowell

Licensed Embalmer No. 4800

P. O. Address Kirkwood 227

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.