

REC'D AUG 11 1939
Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis 13
(If outside city or town limits, write "RURAL")
(d) Street No. 2633 Brannon
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day July
year 1939 hour 8:25 minute _____ A. M.

21. I hereby certify that I attended the deceased from 7/3/39
_____, 19____, to 7/6, 19____.

that I last saw her alive on 7/6, 19____.

and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
Re int. Capsule

Due to: Septicemia
Due to: Sciuitly

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: Cerebral hemorrhage
Re int. Capsule

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(a) Manner of injury !

23. Signature Geo. J. Davis (M.D. or other) _____
Address City Hospital Date signed _____

3. (a) PRINT FULL NAME Mary Reisenacker

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased: July 1 1859
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>0</u>	<u>5</u>	_____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown (City, town, or county) _____ (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature Edward A. Leubner

(b) Address 6464 Chippewa

17. (a) Burial (b) Date thereof July 19, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ofelia

18. (a) Signature of funeral director Wm. J. ...

(b) Address 7111 E. ...

19. (a) JUL 8 1939 (b) J. P. ...
(Date received local registrar) (Registrar's signature)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHILE FILLING IN—USE UNFADING BLACK INK—MAKE A FURNAMENT RECORD

-1 X1951

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Edwin H. Leisinger

Licensed Embalmer No.

40490

P. O. Address

6464 Chippewa

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 this body is not embalmed, above space should be left blank.