

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.

SEP 14 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

27915
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1008**
(c) City **St. Louis** (d) Street No. **Deaconess Hospital** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

Registered No. **7415**

2. PRINT FULL NAME **Joan Audrey Reindl**

(a) Residence, No. **7665 Lindbergh Dr. Richmond Heights st.** (Usual place of abode, if no street address, write county or city) **NR** (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **8/23/1939**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **3**

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Child**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Missouri**

FATHER 13. NAME **W. A. Reindl**

14. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Missouri**

MOTHER 15. MAIDEN NAME **Genevieve Johnson**

16. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Missouri**

17. INFORMANT **W. A. Reindl** (ADDRESS) **7665 Lindbergh Dr. Richmond Heights**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Memorial Park Cem** DATE **8/26/1939**

19. FUNERAL DIRECTOR (NAME) **Robert J. Ambruster** (ADDRESS) **Clayton Road at Concordia Lane**

20. **AUG 29 1939** **J. F. Budick** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8/26/1939** 19

22. I HEREBY CERTIFY, That I attended deceased from **8/23/39** 19, to **8/26/39** 19

I last saw h. or l. alive on **Aug 25** 19**39**. Death is said to have occurred on the date stated above, at **5 A** m. The principal cause of death and related causes of importance were as follows:

Prematurity
hypoxia in mother
precipitate delivery

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) **J. M. Brown** M. D.
(Address) **2867 Union Blvd**

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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.....

Edward H. Bockhorst

Registered Apprentice No.....

working under my personal supervision.

Signed *Edward H. Bockhorst*

Licensed Embalmer No. *2502*

P. O. Address *Blayton Mo*

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.