

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County 3  
(b) City or town St. Louis  
(c) Name of hospital or institution St. Mary's Hospital  
(d) Length of stay: In hospital or institution 70 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM REGH JRD

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

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

6. (b) Name of husband or wife Mrs. Clara Regh 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Jan 11 1866  
(Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 18 If less than one day hr. min.

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

10. Usual occupation Painter

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Mrs. Clara Regh

(b) Address 3513 Evans Ave

17. (a) Burial (b) Date thereof Jan 1st 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Thomas Lechner

(b) Address 1417 N. Market St.

19. (a) DEC 31 1939 (b) J. B. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1  
(c) City or town St. Louis 21  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3513 Evans Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29  
year 1939 hour 6 minute 45 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Primary leukemia Duration \_\_\_\_\_  
Chronic leukemia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations aut PHYSICIAN \_\_\_\_\_  
Of autopsy \_\_\_\_\_ Underline the cause to which death should be charged statistically

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? \_\_\_\_\_

23. Signature Joseph W. Lechner M.D. or other \_\_\_\_\_  
Address St. Louis Date signed \_\_\_\_\_  
(Specify type of place) (Means of injury)

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.

**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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis

**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.**