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13-40
7-39
X23150

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 7959

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis

(c) Name of hospital or institution: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Norvel Joseph Resinger

3. (b) If veteran, name war No. 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Infant 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 20 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>3</u>	_____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Norvel Resinger

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

14. Maiden name Eleanor Sewald

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

16. (a) Informant Mrs. Eleanor Resinger

(b) Address Festus, Mo.

17. (a) Removal (b) Date thereof 9-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Festus, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) SEP 24 1940 (b) J. P. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town Festus (If outside city or town limits, write "RURAL") NR

(d) Street No. 214 Garbarino
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23 year 1940 hour 9:15 minute 0 M.

21. I hereby certify that I attended the deceased from Sept 20 to Sept 23, 1940, that I last saw him alive on Sept 25, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Central hemorrhage cerebral. Duration _____

Due to Birth trauma

Due to _____

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

Major findings: _____
Of operations _____

(Of autopsy Yes) Central hemorrhage cerebral.

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? St. Louis Mo. St. Anthony's Hospital
(Specify type of place)

While at work? _____ (Specify type of place) (b) Means of injury _____

23. Signature John J. Plesner (M. D. or other) _____

Address 506 Olive St. Date signed 9-24-40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Guy W Wilkinson

Licensed Embalmer No. 3575

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 this body is not embalmed, fact should be so stated above.