

FILED NOV 18 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9789**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
DePaul Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: 5 minutes  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4519 Fair Ave  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Ann Reichelt

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Single  
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November 7, 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 0 0 hr. 5 min.

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

10. Usual occupation Child

MOTHER FATHER { 11. Industry or business \_\_\_\_\_

12. Name Charles E. Reichelt  
13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Marian G. Galloway  
15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Charles E. Reichelt  
(b) Address 4519 Fair Ave

17. (a) Burial (b) Date thereof 11/8/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Valhall Cemetery

18. (a) Signature of funeral director Math Hermann & Son  
(b) Address 2161 East Fair Ave

19. (a) NOV 8 1943 J. F. Brueck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7th  
year 1943 hour 4:00 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Nov 7  
1943 to Nov 7 1943  
that I last saw her alive on Nov 7 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
Cerebrospinal Meningococci  
Due to \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(e) Means of injury \_\_\_\_\_  
23. Signature J. F. Brueck (M. D. or other) NO  
Address 15899 Brewer Date signed 11-7-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

---

---

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.

Not embalmed

Signed Francis A. Williamson

Licensed Embalmer No. 3565

P. O. Address St. Louis 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, fact should be so stated above.**