

FILED MAY 15 1944

Registration District No. 316

Primary Registration District No. 30-65

15694

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 yrs. 6 mos.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM D. REIHL (RIEHL)

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

4. Sex Male 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 About 1871
(Month) (Day) (Year)

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

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

10. Usual occupation Farming

11. Industry or business

12. Name W. Riehl
13. Birthplace St. Louis Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Amherst Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof April 19 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Potosi Mo

18. (a) Signature of funeral director H. S. Sparks

(b) Address Potosi Mo

19. (a) 4-19-44 (b) Donna Stahura
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington 94
(c) City or town Potosi
(If outside city or town limits, write "RURAL")
(d) Street No. Unknown
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10,
year 1944 hour 4 minute 55 P. M.

21. I hereby certify that I attended the deceased from April 1, 1943, 19____ to April 10, 1944, 19____;
that I last saw him alive on April 10, 1944, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death General arteriosclerosis Duration _____

Due to _____

Due to _____

Other conditions Mental depression
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

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?

While at work? _____ (Specify type of place) (e) Means of Injury _____

23. Signature H. S. Sparks (M. D. or other) MD
Address H.C.F. W. Farmington Date signed 4-11-44

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

2
43
39
35697

Book 1-1-11

RECEIVED 5-13-44

District Health Officer No. 4

District File Number 544-383

Date Filed 5-13-44

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 *Ernest Sparks*

Licensed Embalmer No. *4387*

P. O. Address *Hickory*

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.