

FILED SEP 1 1945 318

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 7411

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6203 Nottingham Ave
(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 Frances Reinhardt

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

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced, Widowed

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

7. Birth date of deceased April 20 1860
(Month) (Day) (Year)

8. AGE: Years 85 Months 4 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business at Home

MOTHER { 12. Name Theodore Berna
13. Birthplace Germany (City, town, or county) (State or foreign country)
FATHER { 14. Maiden name Susan Krehr
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Emma Reinhardt
(b) Address 6203 Nottingham Ave

17. (a) Burial (b) Date thereof 8 27 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser

(b) Address 4228 So. Kingshighway

19. (a) AUG 26 1945 (b) J. F. Baer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County COU
(c) City or town St. Louis 1714
(If outside city or town limits, write "RURAL")
(d) Street No. 62033 Nottingham Ave 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 24
year 1945 hour 4.50 PM minute _____ M.

21. I hereby certify that I attended the deceased from Aug 20
to Aug 24 1945
that I last saw her alive on Aug 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis chronic
Obstructive acute 2 weeks

Due to _____
Due to _____ 93d
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: None
Of operations _____
Of autopsy None

Duration
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 Philip Schuck (M. D. or other) M.D.
Address 1703 1/2 Grand Date signed 8/27/45

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

Dr Schuck
Grand Park

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

Richard W. Stoverson

Licensed Embalmer No.

4007

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7411

1. PLACE OF DEATH:

(a) County St. Louis Mo
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" add name of township)
(c) Name of hospital or institution:
(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 Frances Reinhardt

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

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

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

7. Birth date of deceased 4 20 1861
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days 4 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-5-48 (b) J.F. Budack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 24
year 1948 hour _____ minute _____ M.

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

Immediate cause of death _____ Duration _____

Due to _____

Due to _____

Other conditions _____
(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

Handwritten signature or initials, possibly "W. H. A."

26063