

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37915**

FILED NOV 20 1945

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 316

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Leveering Hospital D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
Specify whether
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64
(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2901 Garfield 4
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ann Marie Reutenauer

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

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

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

7. Birth date of deceased october 11 1945
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 12
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Adam B. Reutenauer

13. Birthplace Greenport New York
(City, town, or county) (State or foreign country)

14. Maiden name Gastler Osheschus

15. Birthplace Garden city Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Adam B. Reutenauer

(b) Address 2901 Garfield, Hannibal, Mo.

17. (a) Burial (b) Date thereof oct. 24, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand View Burial Park

18. (a) Signature of funeral director Ray P. Schwart

(b) Address 1570 Broadway, Hannibal, Mo.

19. (a) 10-25-45 (b) Dr. E. M. Lucke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month october day 23
year 1945 hour 2 minute _____ A. M.

21. I hereby certify that I attended the deceased from Oct 11
1945, 19to Oct 23, 1945
that I last saw her alive on Oct 10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhagic Dissection
New (born) (arteries) 12 days

Due to Moltu Rh. negative

Due to _____

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

Major findings: Of operations _____

Of autopsy 1610

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 J. P. Dillman M. D. 10/24/45
Address 115 N. 2nd Hannibal Mo Date signed 10/24/45

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

MOTHER FATHER

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 George T. Bond
Licensed Embalmer No. 4373
P. O. Address Hannibal, 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.