. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 8 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29430

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 8258

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: 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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Illinois (b) County: Jersey 999

(c) City or town: Jerseyville (If outside city or town limits, write "RURAL")

(d) Street: RR (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME: Nina Mae Reiss

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: Married

6. (b) Name of husband or wife: Carl Reiss

6. (c) Age of husband or wife if alive: 44 years

7. Birth date of deceased: August (Month) 12 (Day) 1904 (Year)

8. AGE: Years 43 | Months 0 | Days 15 | If less than one day hr. min.

9. Birthplace: Hamburg (City, town, or county) Illinois (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: John Rosa

FATHER 13. Birthplace: Hamburg (City, town, or county) Illinois (State or foreign country)

MOTHER 14. Maiden name: Margaret Banker

MOTHER 15. Birthplace: Hamburg (City, town, or county) Illinois (State or foreign country)

16. (a) Informant: Carl Reiss

(b) Address: Jerseyville, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8-28-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Kampsville, Ill.

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

(b) Address: 4700 Washington Blvd.

19. (a) AUG 29 1947 (Date received local registrar) (b) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27 year 1947 hour 1 minute 20 P.M.

21. I hereby certify that I attended the deceased from Aug 24, 1947, to Aug 26, 1947 that I last saw her alive on Aug 26, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Renal Failure	24 hrs.
Due to: Anaphylactic Reaction	24 hrs.
Due to: Blood Transfusion	24 hrs.
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations

Of autopsy: as above.

PHYSICIAN — Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: Durand Benjamin (M. D. or other) M.D.

Address: 7430 Virginia Ave. Date signed: 8/27/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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. Elmo R. Cadwell

Licensed Embalmer No. 4077

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.