

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2127

10589

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2127			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri				b. COUNTY	
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 73 Year		c. CITY OR TOWN St. Louis		17 9			
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital U				d. STREET ADDRESS (If rural, give location) 6426 Oakland Ave.				D	
3. NAME OF DECEASED (Type or Print) a. (First) Augusta			b. (Middle) Reifeiss			c. (Last)			
4. DATE OF DEATH (Month) (Day) (Year) Mch. 4th 1949			5. SEX Female			6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow			8. DATE OF BIRTH July 29 1875			9. AGE (In years last birthday) 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) St. Louis, Mo. U			
12. CITIZEN OF WHAT COUNTRY? U.S.			13a. FATHER'S NAME Fred Winterberg			13b. MOTHER'S MAIDEN NAME Emma Wehmann			
14. NAME OF HUSBAND OR WIFE Louis Reifeiss Dec'd			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none			
17. INFORMANT'S SIGNATURE OR NAME Viola Reifeiss			ADDRESS 6426 Oakland						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Embolism <del>of</del> cerebrum right						INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Arteriosclerotic heart disease						6 months	
DUE TO (c)		93A							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4200							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Feb. 23, 1949, to Mar. 4, 1949, that I last saw the deceased alive on Mar. 4, 1949, and that death occurred at 11:25 P. M., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Norton John Everson M.D.				23b. ADDRESS 6356 Clayton Road			23c. DATE SIGNED Mar. 5, 1949		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mch 8 1949		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. MAR 7 1949		REGISTRAR'S SIGNATURE J. B. Laster			25. FUNERAL DIRECTOR'S SIGNATURE Wm. Schumacher				
					ADDRESS 3013 Meramec				

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

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Norton Eberoll  
6356 Clayton

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.....

*Jack Haupt*

Student Embalmer No. *231*

working under my personal supervision.

Signed *Jack Haupt*.....

Student Embalmer

Signed

*Francis Williamson*

Licensed Embalmer No. *3562*

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.