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THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 9 1949

State File No. **21572**
Registrar's No. **5705**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY 000	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 17	
c. LENGTH OF STAY (in this place) 12 YRS		d. STREET ADDRESS (If rural, give location) (131) 3600 ARSENAL ST	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY INFIRMARY			

3. NAME OF DECEASED (Type or Print) HERMAN REIFEISS			4. DATE OF DEATH (Month) (Day) (Year) June 29 1949		
a. (First)	b. (Middle)	c. (Last)			

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH APRIL 8 1889	9. AGE (in years last birthday) 60	IF UNDER 1 YEAR Months 2 Days 21	IF UNDER 2 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE CUTTER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MISSOURI 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME LOUIS REIFEISS	13b. MOTHER'S MAIDEN NAME WILHELMINA BOHLE	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME WALTER REIFEISS	ADDRESS 4947 THOLOZAN
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1948X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 97
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR H.B.F.
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22. I hereby certify that I attended the deceased from **Febr. 16 1948** to **June 29, 1949**, that I last saw the deceased alive on **June 29, 1949**, and that death occurred at **5:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)	23b. ADDRESS 5400 Arsenal St	23c. DATE SIGNED 6/30/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 2 1949	24c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. JUL 1 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS 2906 Gravois
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Harold C. Hill

Signed _____
Student Embalmer

Licensed Embalmer No. _____

4347

P. O. Address _____

2906 Grand

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.