

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6649**
2003

FILED MAR 10 1950

318

1003

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) township)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION 515 Fillmore				d. STREET ADDRESS (If rural, give location) 515 Fillmore			
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle)		c. (Last) Reisch		4. DATE OF DEATH (Month) (Day) (Year) 2/27/50	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Aug. 20, 1873	
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Mathew Thudium		13b. MOTHER'S MAIDEN NAME Louise Quest		14. NAME OF HUSBAND OR WIFE Michael	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marie Kolde--5916a Arendes Dr.			
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) fractured hip (R) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Terminal pneumonia					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis MO Mo.		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-4-'49 m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? fall					
22. I hereby certify that I attended the deceased from Mar 4, 1949 to 2/27, 1950 , that I last saw the deceased alive on 2/27, 1950 , and that death occurred at 3:50p m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) M. M. Freund M.D.				23b. ADDRESS 1713 S. Grand		23c. DATE SIGNED 3/1/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/2/50		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. MAR 2 1950		REGISTRAR'S SIGNATURE J. B. Pasater		25. FUNERAL DIRECTOR'S SIGNATURE Walter Kelderle		ADDRESS 3634 Gravois	

WRITE PLAINLY—USING UNFAADING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Frank J. Glavel, Jr.

Signed.....
Student Embalmer

Licensed Embalmer No. *2645*

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.