

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6707**  
Registrar's No. **1750**

FILED MAR 8 1954 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 <b>Missouri</b> b. COUNTY <b>2199</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (in this place) c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>19 4143 Westminister Place.,</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>FRANCES</b> b. (Middle) c. (Last) <b>REINSMITH</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>FEBRUARY 19, 1954</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>1879</b>
9. AGE (In years last birthday) <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Monett, Missouri</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Unknown Reinsmith</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Nil</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Bernice Smith, 4143 Westminister Pl.</b>
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>PYCLOMOPHOSIS</b>  ANTECEDENT CAUSES DUE TO (b) <b>HYDROMOPHOSIS</b> DUE TO (c) <b>CARCINOMA OF BLADDER.</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>CORONARY ARTERY DISEASE</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input checked="" 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.)	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>181X</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2-14-54</b> , 19___, to <b>2-19-54</b> , 19___, that I last saw the deceased alive on <b>2-19-54</b> , 19___, and that death occurred at <b>12:50A.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Paul W. Larson M.P.</b>		23b. ADDRESS <b>1515 Lafayette Avenue</b>	
23a. SIGNATURE (Degree or title)		23c. DATE SIGNED <b>2-19-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>2-21-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cemetery</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>FEB 23 1954</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe, 4700 Washington</b>	
DATE REC'D BY LOCAL REG. <b>FEB 23 1954</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington</b>	

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

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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..

Student.....  
Signature of Student Embalmer

Signed..... *Paul A. Wachter* .....

Licensed Embalmer No. *476*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.