

FILED AUG 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24271**
Registrar's No. **6322**

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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 1yr. 10mo		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 St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 5800 Arsenal St.	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) c. (Last) Reinschmidt		4. DATE OF DEATH (Month) (Day) (Year) July 22, 1955	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH Apr. 12, 1870
9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil	11. BIRTHPLACE (City and State or Foreign Country) Ill.
13a. FATHER'S NAME ?? Schumacker		13b. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS St. Louis Chronic Hospital 5800 Arsenal St	

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		INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease			years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Disease			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemiplegia due to Cerebral Thrombosis		years		

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 **September 19 53** to **July 22**, 19 **55**, that I last saw the deceased alive on **July 22**, 19 **55**, and that death occurred at **9:40 A.m.**, from the causes and on the date stated above.

23a. SIGNATURE Benj M. Janaka, M.D. (Degree or title)	23b. ADDRESS 5800 Arsenal St.	23c. DATE SIGNED 7-22-55
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7/25/55	24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetary
		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG. JUL 22 1955	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Collier Mortuary, 10123 St. Charles Road
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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..

Student.....
Signature of Student Embalmer

Signed *Sheldon Collins*

Licensed Embalmer No. *332*

P. O. Address *10133 St. Charles St. Ann*

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.