

FILED APR 12 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11948

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 7671. PLACE OF DEATH
a. COUNTY ST. LOUIS2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE MO b. COUNTY ST. LOUISb. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normandy c. LENGTH OF STAY (If this place) 8 daysc. CITY OR TOWN St. Ferdinand Township d. Is Residence within limits of a city or incorporated town? Yes No d. FULL NAME OF HOSPITAL OR INSTITUTION NORMANDY OSTEO PATHICe. STREET ADDRESS (If rural, give location) 10175 Mayfair Drive3. NAME OF DECEASED a. (First) EDWARD b. (Middle) REINHARDT c. (Last) REINHARDT DATE OF DEATH MARCH 19th 19565. SEX MALE 6. COLOR OR RACE WHITE7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) NEVER MARRIED8. DATE OF BIRTH SEPT. 10, 1937 9. AGE (In years last birthday) 16 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT10b. KIND OF BUSINESS OR INDUSTRY NONE11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MO12. CITIZEN OF WHAT COUNTRY? U.S.A13a. FATHER'S NAME GRANT A REINHARDT13b. MOTHER'S MAIDEN NAME Beatrice Rackwitz14. NAME OF HUSBAND OR WIFE None15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. NONE17. INFORMANT'S SIGNATURE OR NAME ADDRESS James A. Reinhardt 10175 Mayfair Drive18. 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) Circulatory Failure
ANTECEDENT CAUSES Mitral Stenosis, Aortic Stenosis and Pericarditis
DUE TO (b) and
DUE TO (c) Pneumatic Fever
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Pneumonia & Gastrointestinal hemorrhageINTERVAL BETWEEN ONSET AND DEATH
1 wk.
8 yrs
8 yrs.
2 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 410X ~~440~~20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-11, 1956, to 3-19, 1956, that I last saw the deceased alive on 3-18, 1956, and that death occurred at 5:45 a.m., from the causes and on the date stated above.23a. SIGNATURE (Degree or title) Walter Richardson MD23b. ADDRESS 2335 Brown Rd23c. DATE SIGNED 3-19-5624a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL24b. DATE 3/21/5624c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK24d. LOCATION (City, town, or county) (State) NORMANDY MODATE REC'D BY LOCAL REG. 3-20-56REGISTRAR'S SIGNATURE Herbert R. Dombey MD25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Cullen Kelly 7267 NATL. BRIDGE

(Licensed Embalmer's Statement on Reverse Side)

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

APR 1954

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 *James A. Lam*
Licensed Embalmer No.....
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.