

18507

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 25 1956

318

1003

STATE FILE NUMBER

4496

Registration District No. Primary Registration District 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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		Length of stay in 1b	d. STREET ADDRESS 4662 Idaho Ave (If outside, give location) 15
3. NAME OF DECEASED (Type or print) PETER First REINHARDT Last		4. DATE OF DEATH MAY 8, 1956 Month 8 Day 1956 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 26 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Employee		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 78
13. FATHER'S NAME -- Reinhardt		11. BIRTHPLACE (City and state or country) St. Louis, Mo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME Unknown	
17. INFORMANT Louis Reinhardt 7912 Colleen Ave Address		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) A.S.H.P. DUE TO (c) 420.0			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 4/20/56 to 5/8/56 and last saw her him alive on 5/8/56 Death occurred at 1:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) M. B. Avery MD.		22b. ADDRESS 1515 LAFAYETTE AVE.	
22c. DATE SIGNED 5/8/56.			
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. NAME OF CEMETERY OR CREMATORY Old St. Marcus Cemetery St. Louis Mo	
23c. DATE 5/11/56		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR J. L. Ziegenhein & Sons ADDRESS 7027 Gravois		25. DATE RECD. BY LOCAL REG. MAY 9 1956	
26. REGISTRAR'S SIGNATURE Carl Smith MD m & B			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed C. P. Kudwell
Licensed Embalmer No. 38

P. O. Address 7027 Ave

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.