

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 29 1957

State File No. 44872

318

1003

Registrar's No. 12037

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. 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) _____	c. CITY OR TOWN St Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Louis City Hospital			e. STREET ADDRESS (If rural, give location) 23 1517 S 7th Street		
3. NAME OF DECEASED (Type or Print) a. (First) Katherine		b. (Middle) _____	c. (Last) Reifschneider	4. DATE OF DEATH (Month) (Day) (Year) Dec 28 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 24 1883	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____
IF UNDER 2 HRS. Hours _____ Min. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY? U S			13a. FATHER'S NAME Fred Kahbein		
13b. MOTHER'S MAIDEN NAME Katherine Behn			14. NAME OF HUSBAND OR WIFE Louis (Deceased)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Catherine Schuster 3720 Salena 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diphtheria Mellitus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 260x		20. AUTOPSY? <input type="checkbox"/> 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.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 150A m., from the causes and on the date stated above.					
23a. SIGNATURE (Name or title) Joseph M. Schubert, M.D.			23b. ADDRESS 1300 Clark		23c. DATE SIGNED 1/4/57
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12/31/56	24c. NAME OF CEMETERY OR CREMATORY New St Marcus Cemetery	24d. LOCATION (City, town, or county) (State) St Louis County Mo		
DATE REC'D BY LOCAL REG. DEC 31 1956	REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen Av		

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 *Reinhold K. Lohmann*.....

Licensed Embalmer No. *3395*
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.