

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1143

300 1-56

2

1. PLACE OF DEATH a. COUNTY <i>Buchanan.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Joseph</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hospital No. 2.</i>		Length of stay in lb <i>2 yrs. 8 mos. 15 days</i>	d. STREET ADDRESS (If outside, give location) <i>332 Indiana.</i>

3. NAME OF DECEASED (Type or print) First <i>RALPH.</i> Middle <i>—</i> Last <i>REICHERT</i>			4. DATE OF DEATH Month <i>10-</i> Day <i>22-</i> Year <i>1957.</i>	
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5. SEX <i>Male.</i>	6. COLOR OR RACE <i>white.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-15-1876.</i>	9. AGE (In years last birthday) <i>81</i>	IF UNDER 1 YEAR Months <i>4</i> Days <i>7</i>	IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beer Brewing</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Brewing of Beer.</i>	11. BIRTHPLACE (City and state or country) <i>Germany.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A. (naturalized)</i>
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13. FATHER'S NAME <i>Josef Reichert</i>	14. MOTHER'S MAIDEN NAME <i>Unknown.</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No.</i>	16. SOCIAL SECURITY NO. <i>441-89-200 Has S.S. Pension</i>	17. INFORMANT <i>Mrs. David.</i>	Address <i>7093 Fecarosa Blvd. L.A. Calif.</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>chronic myocarditis.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Yrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>arterio-sclerosis.</i>	<i>Yrs</i>
	DUE TO (c) <i>4221</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Brain Syndrome associated with possible brain disease.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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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.)
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20c. TIME OF INJURY Hour <i>—</i> Month <i>—</i> Day <i>—</i> Year <i>—</i> a. m. <i>—</i> p. m. <i>—</i>	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 <i>4221</i>	COUNTY	STATE
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21. I attended the deceased from <i>3-22-55</i> , to <i>10-22-57</i> and last saw ^{her} him alive on <i>10-22-57</i> . Death occurred at <i>12:22</i> P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. H. Monahan</i>	(Degree or title) <i>M.D.</i>	22b. ADDRESS <i>State Hospital No. 2, St. Joseph, Mo.</i>	22c. DATE SIGNED <i>10-22-1957</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-25-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive Cemetery</i>	23d. LOCATION (City, town, or county) <i>St. Joseph, Mo.</i>	(State)
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24. FUNERAL DIRECTOR <i>Herman W. Sidemeyer</i>	ADDRESS <i>St. Joseph Mo</i>	25. DATE RECD. BY LOCAL REG. <i>Oct. 25, 1957</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

49

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..... *Robert S. Apple*

Licensed Embalmer No. *7300*

P. O. Address *St. Joseph, Mo.*

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.