Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-015594 2 3342

FILED APR 20 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: MARIAN HOSPITAL — Length of stay in 1b: 1 Hour

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: JeFFERSON
c. CITY OR TOWN: HOUSE SPRINGS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): ROUTE 1 — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First EDWARD Middle Last REISS

4. DATE OF DEATH Month APRIL Day 3 Year 1959

5. SEX MAle

6. COLOR OR RACE WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH MAR. 10 1887

9. AGE (In years last birthday) 72 — 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): RETIRED BREWERY WORKER

10b. KIND OF BUSINESS OR INDUSTRY: BUSCH BREWERY

11. BIRTHPLACE (City and state or country): Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: GEORGE REISS

13b. MOTHER'S MAIDEN NAME: MAGDALENA BURGE

14. NAME OF ~~HUSBAND~~ OR WIFE: CATHERINE REISS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: CATHERINE REISS — Address: HOUSE SPRINGS Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Cervical Glands of neck — INTERVAL BETWEEN ONSET AND DEATH: 8 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 198.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 May 30/58, to Apr. 3/59 and last saw her/him alive on Mar. 28/59
Death occurred at 10 00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. M. Rimmer (Degree or title) M.D.

22b. ADDRESS 3014 S. Jefferson

22c. DATE SIGNED Apr 3/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE APRIL 6 1959

23c. NAME OF CEMETERY OR CREMATORY: NEW ST. MARCUS

23d. LOCATION (City, town, or county) ST. LOUIS (State) Mo

24. FUNERAL DIRECTOR: Thomas Kutis — ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG. APR 3 '59

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. 4349

P. O. Address 2906 Travis

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.