

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 29 1960

318

Primary Registration District No.

1003

Registrar's No.

5302

-60-024888

STATE FILE NUMBER

| | | | | | | |
|--|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u> </u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St Louis</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> | | Length of stay in 1b <u>177 DAYS</u> | c. CITY OR TOWN <u>BRENTWOOD</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VAH, 915 NO. GRAND AVE.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>2331 ARMALEE</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>C.</u> Last <u>REIFSTECK</u> | | | 4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1960</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/16/95</u> | 9. AGE (last birthday) <u>64</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PLASTERER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>KIRKWOOD, MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>HENRY REIFSTECK</u> | | 13b. MOTHER'S MAIDEN NAME <u>ELIZABETH SCHULZ</u> | | 14. NAME OF HUSBAND OR WIFE <u>WILLA REIFSTECK</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW-I</u> | | 16. SOCIAL SECURITY NO. <u>WA-I</u> | 17. INFORMANT <u>WILLA REIFSTECK, 2331 ARMALEE, BRENTWOOD MO</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> | | | | | <u>2-3 DAYS</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | <u>6 DAYS</u> | |
| DUE TO (b) <u>CEREBROVASCULAR HEMORRHAGE</u> | | | | | <u>12 YEARS</u> | |
| DUE TO (c) <u>GENERALIZED ATHEROSCLEROSIS</u> <u>331x</u> | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not referred to in terminal disease condition given in PART I (a) <u>BENIGN PROSTATIC HYPERPLASIA WITH CYSTITIS, PYELONEPHRITIS</u> <u>URETERITIS AND</u> | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u> | | | | | | |
| 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 <u>11/24/59</u> to <u>5/19/60</u> and last saw <u>him</u> alive on <u>5/19/60</u> . Death occurred at <u>12:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>FRANKLIN H. WEBSTER M.D.</u> | | | 22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u> | | 22c. DATE SIGNED <u>5/19/60</u> | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSAL <u>5/23/60</u> | | 23b. DATE <u>5-23-1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u> | | |
| 23d. LOCATION (City, town, or county) <u>JEFFERSON BARRACKS MO</u> | | 23e. STATE <u>MO</u> | | | | |
| 24. FUNERAL DIRECTOR <u>MITTELBERG</u> | | ADDRESS <u>WEBSTER GRAVES MO</u> | | 25. DATE RECD. BY LOCAL REG. <u>MAY 20 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

YH 80

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

Stanley H. Nixon

Licensed Embalmer No.

419

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.