

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027358

Registration District No. **042** Primary Registration District No. **1000** Registrar's No. **920**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

FILED AUG 5 1963

VS 300	DATE AMENDED
Rev. 4/59	
1 5117	
2 5117	
3 .2	
4 1	
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94200	
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12 86-0	
13 1-0	
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	
ITEM NO.	INSTEAD OF
BY AFFIDAVIT OF	DOCUMENT
SHOULD READ	MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b life	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunnyslope Nurs. Home		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 816 No. 9th St. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LENA REINKE		First LENA Middle REINKE Last REINKE	4. DATE OF DEATH Month July Day 17 Year 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) 83 IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HR: Hours 0 Min. 0
11a. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME August Reinke		13b. MOTHER'S MAIDEN NAME Amelia Groah	14. NAME OF HUSBAND OR WIFE never married
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. [REDACTED]	17. INFORMANT Address Mrs. Beatrice Purkett 305 So. 15
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Renal Disease DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) [REDACTED] Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 type="checkbox"/> NO <input checked="" 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 [REDACTED] a.m. [REDACTED] p.m. Month, Day, Year [REDACTED]		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY [REDACTED] STATE [REDACTED]	
21. I attended the deceased from 7/16/63 to 7/17/63 and last saw her alive on 7/16/63 Death occurred at [REDACTED] m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W.E. Johnson MD		22b. ADDRESS SOCIAL WELFARE BOARD 10th & Olive, St. Joseph, Mo.	22c. DATE SIGNED 7/19/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/20/1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Mora	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
24. FUNERAL DIRECTOR Heston-Bowman, St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Aug 1, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

USE BLACK INK OR TYPEWRITER RIBBON

627193-108

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 Theron O Smith

Licensed Embalmer No. 3928

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.

Permit issued 7-20-63
0-08