

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-032690**  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 162 Primary Registration District No. 5595 Registrar's No. 100

**FILED SEP 3 1963**

VS 300  
Rev. 4/59

1 0500  
2 0500  
3  
4 0  
5 0  
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7 0  
8 2  
9 9198  
10 43  
11 050  
12 90-3  
13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>JEFFERSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>JEFFERSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ROCK TOWNSHIP</b>		c. CITY OR TOWN <b>NEAR ARNOLD Mo</b>	
Length of stay in 1b <b>LIFETIME</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>NEAR ARNOLD Mo</b>		d. STREET ADDRESS (If outside, give location) <b>HIGHWAY 61-67</b>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH MICHAEL REICH</b>			4. DATE OF DEATH Month Day Year <b>AUG 29. 1963</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 25. 1948</b>
9. AGE (last birthday) <b>15</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		13a. FATHER'S NAME <b>DR. OLIVER F. REICH</b>	
13b. MOTHER'S MAIDEN NAME <b>HAZEL GAINES</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>DR. O.F. REICH</b>		Address <b>ARNOLD Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot to Base of Skull</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 checked="" 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.) <b>Hunting Accident.</b>	
20c. TIME OF INJURY Hour a.m. <b>8:00</b> Month, Day, Year <b>8-29-63</b>			
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.) <b>Woods</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Rock Twp JEFF Mo.</b>
21. I attended the deceased from <b>CORNER'S VIEW</b> and last saw her/him alive on <b>8:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James C. [Signature] M.D. Coover</b>		22b. ADDRESS <b>Festus Mo</b>	22c. DATE SIGNED <b>8/29/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>AUG 31-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>IMMACULATE CONCEPTION CEM. ARNOLD Mo</b>	
24. FUNERAL DIRECTOR <b>HEILIGTAG - IMPERIAL Mo</b>		25. DATE RECD. BY LOCAL REG. <b>8/30/63</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 Arthur W. Hultig

Licensed Embalmer No. 3872

P. O. Address Imperial 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.