

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032866  
STATE FILE NUMBER.

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 197

**FILED SEP 4 1963**

VS 300  
Rev. 4/59

1 0595

2 0170

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4 1

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12 1-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		Length of stay in 1b <b>3 weeks</b>	c. CITY OR TOWN <b>Hale,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chillicothe Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Anna Deardorff, Home.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CLARA MATILDA</b> Middle <b>REINITZ</b> Last		4. DATE OF DEATH Month <b>Aug.</b> Day <b>28th</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/5/1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>71</b> IF UNDER 1 YEAR: Months <b>23</b> Hours <b></b> Min. <b></b> IF UNDER 24 HR: Hours <b></b> Min. <b></b>
11. BIRTHPLACE (City and state or country) <b>Alexandria, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William zJ. Dienst</b>		13b. MOTHER'S MAIDEN NAME <b>Sophia Reinitz</b>	
14. NAME OF HUSBAND OR WIFE <b>Rev. Herman Reinitz</b>		17. INFORMANT Address <b>Mrs Anna Deardorff, Hale, Mo.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Terminal</b> DUE TO (b) <b>Carcinoma of Rectum</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>metastasis to the Liver</b>		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 <b></b> a.m. <b></b> p.m. <b></b> Month, Day, Year <b></b>	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 <b></b> STATE <b></b>
21. I attended the deceased from <b>Jan 10-59</b> to <b>Aug 28-63</b> and last saw her alive on <b>Aug 28-63</b> Death occurred at <b>11</b> P M on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Joseph A. Conrad M.D.</b>		22b. ADDRESS <b>Chillicothe, Mo.</b>	
22c. DATE SIGNED <b>Aug 29-63</b>		22d. DATE SIGNED (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/31/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery, Wayland, Missouri</b>	
23d. LOCATION (City, town, or county)		24. FUNERAL DIRECTOR ADDRESS <b>Clifford W. Austin F-H Hale, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>Aug 29, 1963</b>		26. REGISTRAR'S SIGNATURE <b>Annalie Taylor</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 \_\_\_\_\_

*Clifford W. Austin*

Licensed Embalmer No. 3233

P. O. Address Tina, Missouri

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.