

2 2 1939  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

30142

State File No. \_\_\_\_\_  
Registrar's No. 1497

Registration District No. 784

Primary Registration District No. 101

1. PLACE OF DEATH: 1  
(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days.  
(Specify whether  
In this community 30 years.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town Carsonville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8545 Jane Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Carrie Riemenschneider 552

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Jacob 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 9 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 5 12 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation nil.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Andrew Hale

13. Birthplace Ind.  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Southern  
(City, town, or county) (State or foreign country)

15. Birthplace Ind.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ralph H. Cox

(b) Address 8545 Jane Ave.

17. (a) Burial (b) Date thereof Aug. 24/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 N. Simpson Ave.

19. (a) AUG 26 1939 (Date received local registrar) R. R. Mays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21  
year 1939 hour 10 minute 35 P. M.

21. I hereby certify that I attended the deceased from 8/19/39  
\_\_\_\_\_ 19 to 8/21/39 19  
that I last saw her alive on 8/21/39  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral Hemorrhage Duration 8/17/39

Due to Hypertensive Heart Disease ?

Due to 95 1/2

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature James Donald M.D. (M. D. or other)  
Address St. Louis County Hospital Date signed 8/22/39

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Geo. W. Clark*

Licensed Embalmer No. *1661.*

P. O. Address *1125 Hodiama*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**