

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 19 1941
Registration District No. _____

Primary Registration District No. 4476

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Malta Bend
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community most life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline 91
(c) City or town Malta Bend
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John Fred Rieks
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 23 year 1941 hour 3 minute 30 A. M.

4. Sex MALE 5. Color or race White
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Hilda Rieks
6. (c) Age of husband or wife if alive? _____ years
7. Birth date of deceased: Feb 14 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 19, 1940 to Feb 22, 1941, that I last saw him alive on Feb 22, 1941 and that death occurred on the date and hour stated above.
Immediate cause of death: Influenza with bronchial complications Duration 4 days

8. AGE: Years 57 Months 11 Days 9 If less than one day _____ hr. _____ min.

Due to _____
Due to 37W
Other conditions Bronchial Asthma 6 years
(Include pregnancy within 3 months of death)

9. Birthplace Osborne Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business none

MOTHER FATHER
12. Name Herman Rieks
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Bertha Rieks
15. Birthplace Germany
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs John Rieks
(b) Address Malta Bend mo

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? _____

17. (a) Burial (b) Date thereof Feb 25 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Grand Oak

23. Signature Robert R Stanley (Mr & mother) P.O.
Address Malta Bend, Mo Date signed 2, 25, 41
(Specify type of place) (e) Means of injury

18. (a) Signature of funeral director Don Short
(b) Address Marshall mo

19. (a) 3-28-41 (b) Raymond
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

RECEIVED
District Health Officer No. 8
Date Filed 3-14-41
File Number

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.....

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

Signed Donald W. Short.....

Licensed Embalmer No. 3757.....

P. O. Address.....

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