

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **38119**  
Registrar's No. **2356**

FILED DEC 10 1942

Registration District No. **184** Primary Registration District No. **200**

96  
0  
0

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Pine Crest Nursing Home 4  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME JOHN RIEDEL

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower

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

7. Birth date of deceased November 6th, 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

77 0 3 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Unemployed

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

MOTHER FATHER { 12. Name Valentine Riedel 9

{ 13. Birthplace Unknown (City, town, or county) (State or foreign country) 9

{ 14. Maiden name Katherine Unknown 9

{ 15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Dr. A. B. Lambrecht

(b) Address 5135 Page Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/42 (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Robert J. Ambruster

19. (a) NOV 10 1942 (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **100**

(a) State Missouri (b) County 17

(c) City or town St. Louis **9**  
(If outside city or town limits, write "RURAL")

(d) Street No. 1939 N. Union Ave  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 9th year 1942 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from November 4th, 1942, to November 9, 1942  
that I last saw him alive on November 8th, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to 8301

Due to \_\_\_\_\_

Other conditions Arterio Sclerosis  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 [Signature] (M. D. or optician) \_\_\_\_\_  
Address Manchester, Mo Date signed 11/9/42

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

*Edward J. Bookhardt*

Licensed Embalmer No.

*2502*

P. O. Address

*Cleyton Rd*

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, fact should be so stated above.

101 101