

Registration District No. **1818**

Primary Registration District No. **1003**

Registrar's No. **6911**

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

**1. PLACE OF DEATH:**

(a) County.....  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Sisters Of the Poor 5-3400 Grand  
(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** Mary Catherine Risse

3. (b) If veteran, name war..... None

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..... George J. Risse

6. (c) Age of husband or wife if alive..... Deceased years

7. Birth date of deceased January 6th, 1873  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>71</u>	<u>6</u>	<u>29</u>	hr. min.

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

10. Usual occupation House wife

11. Industry or business.....

12. Name Libory Sandbothe

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

14. Maiden name Cunigunda Raab

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

16. (a) Informant Mrs. Leonard Schmitz

(b) Address Westphalia, Mo.

17. (a) Burial (b) Date thereof 8-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Koeltztown, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) AUG 7 1944 (b) J. F. Bredack  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Osage **76**

(c) City or town Koeltztown, Mo.  
(If outside city or town limits, write "RURAL") **NR**

(d) Street No.....  
(If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 5  
 year 1944 hour 5 minute 00 A.M.

21. I hereby certify that I attended the deceased from Aug 1, 1944  
~~Aug 1, 1944~~ 1944 to Aug 5, 1944 1944  
 that I last saw him alive on Aug 1, 1944 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Chronic myocarditis, 1 year

Due to.....  
arterio-sclerosis, 1 year

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations none  
 Of autopsy none

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

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

(a) Accident, suicide, or homicide (specify) NO

(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?  
(Specify type of place)

While at work?.....  
(e) Means of injury

13. Signature R. A. Schumacher (M. D. or other) **MB**

Address 3318 S Grand Date signed 8-5-44

202 030

**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..... *Albert G. Hoff*.....

Licensed Embalmer No..... *2971*.....

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, fact should be so stated above.**