

S. No. 2  
M-2-43  
5-17-39  
P-1 X35697

#55103

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11576

State File No.

FILED APR 5 1946  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2960

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... **St. Louis, Missouri**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**St. Louis City Hospital-Max C. Starkloff**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... **0** (Specify whether)

In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Mo.** (b) County..... **St. Louis**

(c) City or town..... **ST LOUIS**  
(If outside city or town limits, write "RURAL")

(d) Street No. **5285 WATERMAN**  
(If rural, give location)

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

3. (a) PRINT FULL NAME..... **WILLIAM RIDDELL**

3. (b) If veteran..... name war.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **March** day..... **28th**  
year..... **1946** hour..... **6:15** minute..... **P** M.....

4. Sex..... **MALE**

5. Color or race..... **White**

6. (a) Single, widowed, married, divorced..... **MARRIED**

6. (b) Name of husband or wife..... **MARY E. RIDDELL**

6. (c) Age of husband or wife if alive..... **83 years**

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

21. I hereby certify that I attended the deceased from..... **3/9/46**  
19..... to..... **3/28/46** 19.....

that I last saw him alive on..... **3/28/46** 19.....  
and that death occurred on the same and hour stated above.

Immediate cause of death..... **Peritonitis**

Duration.....

8. AGE:

Years	Months	Days	If less than one day
<b>85</b>	<b>7</b>	<b>19</b>	hr. min.

Due to..... **Perforation of sigmoid colon Regional perforation of colon**

Due to..... **Perforation of sigmoid colon**

Other conditions.....  
(Include pregnancy within 3 months of death)

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

10. Usual occupation..... **Hotel Steward**

11. Industry or business..... **Retired**

12. Name..... **Unknown Riddell**

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

14. Maiden name..... **Unknown**

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

16. (a) Informant..... **Miss Ora Hill**

(b) Address..... **5285 Waterman**

17. (a) **BURIAL** (b) Date thereof..... **MAR 30-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Bellefontaine**

18. (a) Signature of funeral director..... **Unknown**

(b) Address..... **1905 Union Blvd**

19. (a) **MAR 29 1946** (b) **J. F. Bredek**  
(Date received by Registrar) (Registrar's signature)

Major findings:..... **Cept of pancreas**

..... **Perforation of sigmoid colon**

..... **Peritonitis**

..... **Schistosoma granulosa**

PHYSICIAN.....

Underline name of physician who attended the deceased and was charged statistically.

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) Means of injury.....

23. Signature..... **Pat Thomas** (M. D. or) **3/28/46**  
Date signed

Address..... **1515 Lafayette**

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

10482

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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 Albert R. Thompson Jr

Licensed Embalmer No. # 4237

P. O. Address St. Louis, Mo

**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.**