No. 300
10-48

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10569
3033

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6215 Mardel

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri. b. COUNTY: Vou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 17
d. STREET ADDRESS (If rural, give location): 6215 Mardel 9

3. NAME OF DECEASED (Type or Print)
a. (First): John b. (Middle): W. c. (Last): Riess

4. DATE OF DEATH (Month): April (Day): 1 (Year): 1949

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower 2
8. DATE OF BIRTH: Sept. 24, 1876
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Missouri 0
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Fred Riess
13b. MOTHER'S MAIDEN NAME: Margaret Sprahn
14. NAME OF HUSBAND OR WIFE: Clara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mr. Harold Bohlmann 6215 Mardel Ave.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure; asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer of head of pancreas

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): 4 1/2
DUE TO (c): 15 X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1943, *to* 4-2, 1949, *that I last saw the deceased alive on* 3-25, 1949, *and that death occurred at* 10:40p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm B Kornet 0
23b. ADDRESS: 4500 Olive St.
23c. DATE SIGNED: 4/2/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4-4-49.
24c. NAME OF CEMETERY OR CREMATORY: New Bethlehem Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis Missouri.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: APR 4 J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Math Hermann & Son, Inc. 2161 E.Fair Ave.

(Licensed Embalmer's Statement on Reverse Side)

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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Student _____
Student Embalmer

Signed William G. Buchholz

Licensed Embalmer No. 2110 O

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.