

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36778**
9416

FILED NOV 12 1952

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2539	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. ANTHONY'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 23 1716th DOLMAN	

3. NAME OF DECEASED (Type or Print) a. (First) DOROTHY b. (Middle) MAE c. (Last) RIES			4. DATE OF DEATH (Month) (Day) (Year) OCT 10 1952		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 16 1930	9. AGE (In years last birthday) 22	10 UNDER 1 YEAR Months Days	11 UNDER 15 HRS Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE CLERK		10b. KIND OF BUSINESS OR INDUSTRY GRESEDICK BREWERY		11. BIRTHPLACE (City and State or Foreign Country) MISSOURI		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME AUGUST MILLER		13b. MOTHER'S MAIDEN NAME MELVA STEIN		14. NAME OF HUSBAND OR WIFE JEROME RIES	
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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. 496-28-2868		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JEROME RIES 1716th DOLMAN	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocarditis & acute dilation - cerebral		INTERVAL BETWEEN ONSET AND DEATH hrs.
	ANTECEDENT CAUSES DUE TO (b) Multiple emboli from thrombosis of ovarian veins -		
	DUE TO (c) marked tracheo-bronchitis.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Twin multiple pregnancy -			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE. (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 6450
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22. I hereby certify that I attended the deceased from **2/21**, 19**52**, to **10/10**, 19**52**; that I last saw the deceased alive on **10/10**, 19**52**, and that death occurred at **2:20 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. W. ...	23b. ADDRESS 3800 Wilming Ave	23c. DATE SIGNED 10/11/52
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24a. BURIAL/CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE OCT. 13 1952	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. OCT 14 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kulis 2906 Marquis
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(Licensed Embalmer's Statement on Reverse Side)

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

Dying Bed

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 Howard C. Dill

Licensed Embalmer No. 434791

P. O. Address 2906 Haveris

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.