

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24286

FILED AUG 15 1955

State File No.

6417

318

1003

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 24286	
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		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital				STREET ADDRESS (If rural, give location) 18 4514 Clayton			
3. NAME OF DECEASED a. (First) Herman b. (Middle) L c. (Last) Risse				4. DATE OF DEATH (Month) (Day) (Year) July 23 1955			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH Aug 16 1905	
9. AGE (In years last birthday) 49		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Cobbler		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME George Risse			13b. MOTHER'S MAIDEN NAME Katherine Sandbode			14. NAME OF HUSBAND OR WIFE ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 492-03-9539		17. INFORMANT'S SIGNATURE OR NAME Henry Risse		ADDRESS 5221 Theodosia	
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) Pulmonary infection ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Pulmonary embolism rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease Conditions contributing to the death but not related to the disease or condition causing death. Knownged arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 5 days 3 days > 7 years	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) 4200			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 7/1 , 19 55 , to 7/23 , 19 55 , that I last saw the deceased alive on 7/22 , 19 55 , and that death occurred at 4:45 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Joseph M. Smith, M.D.				23b. ADDRESS 701 N. 1st St.		23c. DATE SIGNED 7/29	
24a. BURIAL/CREMATION REMOVAL (Specify) Removal		24b. DATE July 26 1955		24c. NAME OF CEMETERY OR CREMATORY Resurrection		24d. LOCATION (City, town, or county) (State) St. Louis Co. MO	
DATE REC'D BY LOCAL REG. JUL 26 1955		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. GENERAL DIRECTOR'S SIGNATURE Thomas Ruten 2906 Harris		ADDRESS _____	

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

(Licensed Embalmer's Statement on Reverse Side)

3203 S
MAY 11 1968

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.....
Signature of Student Embalmer

Signed *Samuel C Hill*.....

Licensed Embalmer No. *439*

P. O. Address *2906*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.