

FILED AUG 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28624

State File No.

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 158

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>Marshall, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>9 Days</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>			
e. STREET ADDRESS (If rural, give location) <u>4646 Carrie</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Albert</u>	b. (Middle) <u>Jerome</u>	c. (Last) <u>Rieth</u>	4. DATE OF DEATH (Month) (Day) (Year)	<u>Aug.</u> <u>15</u> <u>1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 12-1912</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 24 HRS. Days <u>3</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver for-Dyer & Ohare</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Fred M. Rieth</u>	13b. MOTHER'S MAIDEN NAME <u>Genivieve Hoffman</u>	14. NAME OF HUSBAND OR WIFE <u>Marie Meurer.</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>599-05-6735</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Albert J. Rieth-St. Louis, Mo.</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>8 Aug</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Infarction</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Ruptured Aortic Aneurysm</u> DUE TO (c) <u>Peritonitis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>578x</u>			

19a. DATE OF OPERATION <u>Aug 7 - 1955</u>	19b. MAJOR FINDINGS OF OPERATION <u>Ruptured Aortic Aneurysm - Peritonitis</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <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 Aug 7, 1955, to Aug 15, 1955, that I last saw the deceased alive on Aug 15, 1955, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Harold Marshall M.D.</u>	23b. ADDRESS <u>Marshall</u>	23c. DATE SIGNED <u>8/16/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8/18/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>8-14-55</u>	REGISTRAR'S SIGNATURE <u>Carl S. Neal</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>deputy of Leslie Swanson - Marshall, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

NOV 8 1955

AUG 25

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.....
J. Leslie Swenson

Licensed Embalmer No. *231*

P. O. Address *Marshall*

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.