

FILED NOV 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **38787**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9689**

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 town or township) St. Louis, Missouri		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		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 (If not in hospital or institution, give street address or location) BARNES HOSPITAL			
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) F	
c. (Last) Richter, Sr.		4. DATE OF DEATH (Month) (Day) (Year) November 5, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 8, 1901
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 22 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.P.K. South Western Telephone Co.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Fred W. Richter		13b. MOTHER'S MAIDEN NAME Frieda Schmedle	
14. NAME OF HUSBAND OR WIFE Loretta M. Spille		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. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Loretta M. Richter-4123 Blow St.	
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) Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 5 Years		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443x	
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) (Min.)	
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 10/18 , 19 55 , to 11/5 , 19 55 , that I last saw the deceased alive on 11/5 , 19 55 , and that death occurred at 10:00 p m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. V. Bradley M. D.		23b. ADDRESS BARNES HOSPITAL	
23c. DATE SIGNED 11/6/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Nov. 9, 1955		24c. NAME OF CEMETERY OR CREMATORY St. Paul's Churchyard	
24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Carl Smith M.D. Hachew-Kellale - 3634 Gravois Ave.	
DATE REC'D BY LOCAL REG. NOV 7 1955		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Carl Smith M.D. Hachew-Kellale - 3634 Gravois Ave.	

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

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..... *Robert C. Wheeler*

Licensed Embalmer No. *210*

P. O. Address *.....*

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.