

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 18 1956

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10702**

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1.		d. STREET ADDRESS (If outside, give location) 3011 Lemp	

3. NAME OF DECEASED (Type or print) First HENRY Middle W Last RIECHMANN			4. DATE OF DEATH Month NOV. Day 21, Year 1956		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1887	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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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 (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Unk Riechmann	14. MOTHER'S MAIDEN NAME Christine Unk.
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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) no none	16. SOCIAL SECURITY NO. Unk	17. INFORMANT Elenora Riechmann	Address 3011 Lemp
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADVANCED EDEMA AND ASCITES		INTERVAL BETWEEN ONSET AND DEATH 6 MOS
DUE TO (b) LAENNEC'S CIRRHOSIS OF LIVER		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 581-1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from **9/18/56** to **11/21/56** and last saw her alive on **11/21/56**
Death occurred at **5:20 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert Owen, M.D. (Degree or title)	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 11/23/56.
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11-24-56	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR'S ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. NOV 23 1956	26. REGISTRAR'S SIGNATURE Carl Smith MD
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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *David Van Fossen*

Licensed Embalmer No. *42*

P. O. Address *St Louis*

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.