

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9617

State File No.

FILED MAR 18 1957

BIRTH NO.		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>160</u>		
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>2 yrs.</u>		c. CITY OR TOWN <u>Sedalia</u> <u>08040</u>		d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u> <u>0</u>				e. STREET ADDRESS (If rural, give location) <u>2505 Dennis Road</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Max</u> b. (Middle) <u>Riecke</u> c. (Last) <u>Riecke</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 9, 1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>May 18, 1872</u>		
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 2 HRS. Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Nichols, Iowa</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Carl Riecke</u>			13b. MOTHER'S MAIDEN NAME <u>Henrietta Hagar</u>			14. NAME OF HUSBAND OR WIFE <u>Linnie Reed Riecke</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>G. W. Riecke, Sedalia, Missouri</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uraemia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Prostatic Obstruction</u> DUE TO (c) <u>Parkinsons disease, Chronic Cardiac</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Valvular disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>610x</u>					20. AUTOPSY? <u>2</u> YES ☐ NO ☒	
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 ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>Jan 1957</u> , to <u>March 9, 1957</u> , that I last saw the deceased alive on <u>Mar 6, 1957</u> , and that death occurred at <u>8:30 am.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>R. L. Walter M.D.</u>				23b. ADDRESS <u>Sedalia Mo</u>		23c. DATE SIGNED <u>Mar 11-57</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>March 12, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>Mar 12, 1957</u>		REGISTRAR'S SIGNATURE <u>Frances Shelby</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Keckart</u>		ADDRESS <u>Sedalia, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

GILLESPIE FUNERAL HOME

5410

STATE OF IOWA
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

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 *Russell C. Maag*.....

Licensed Embalmer No. *4809*.....

P. O. Address *Sedalia,*.....

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.