No. 300
10.48

FILED JUN 3 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19211

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4728

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 01 3156 N. 13th -

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE N/O
b. COUNTY
c. CITY OR TOWN St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 1269 0 3156 N. 13th

3. NAME OF DECEASED (Type or Print) a. (First) Caroline b. (Middle) c. (Last) Riley

4. DATE OF DEATH (Month) (Day) (Year) 5-20-1957

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 2-24-1878
9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (City and State or Foreign Country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME — Waldbeser
13b. MOTHER'S MAIDEN NAME Minnie —
14. NAME OF HUSBAND OR WIFE Thomas J. Riley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Thomas J. Riley - 3156 N. 13th

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) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 420.1
20. AUTOPSY? 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* 1957, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 1:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 3
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 5/20/57

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 5-22-1957
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) St. Louis (State) N/O

DATE REC'D BY LOCAL REG. MAY 20 '57
REGISTRAR'S SIGNATURE J Earl Smith MD acm
25. FUNERAL DIRECTOR'S SIGNATURE Edward Koch + Son - 3516 N. 14th ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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 embalm

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Foron E. Percy

Licensed Embalmer No. 4094

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu 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.