

FILED JUL 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26497**
Registrar's No. **4376**

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY St. Louis

b. CITY OR TOWN St. Louis c. LENGTH OF STAY (in this place) 6 days
c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital e. STREET ADDRESS (If rural, give location) 27 5988 Dupree St.

3. NAME OF DECEASED a. (First) Richard b. (Middle) Carl c. (Last) Riedel 4. DATE OF DEATH (Month) (Day) (Year) 5 7 57

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH 2-6-57 9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Days _____ IF UNDER 24 HRS. Hours _____ Mins. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Walter Charles Riedel 13b. MOTHER'S MAIDEN NAME Jean Hollenbeck 14. NAME OF HUSBAND OR WIFE Single

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 Alice Partridge ADDRESS 500 S. Kingshighway

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Amyotonia Congenita INTERVAL BETWEEN ONSET AND DEATH _____

ANTECEDENT CAUSES
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
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. 744.1

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 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) _____ 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 5-2, 1957, to 5-7, 1957, that I last saw the deceased alive on 5-7, 1957, and that death occurred at 4:05 ^{A.} m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Barbara Jones, M.D. 23b. ADDRESS Childrens Hospital 23c. DATE SIGNED 5-7-57

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 5-8-57 24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem. 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG. MAY 8 '57 REGISTRAR'S SIGNATURE J. Carl Smith MD 25. FUNERAL DIRECTOR'S SIGNATURE WHITE CHAPEL, FERGUSON, MO. ADDRESS _____

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 Eleanore Poince.....
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Licensed Embalmer No.....

P. O. Address Jennings.....

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.