

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
11036

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11036

S. 300
r. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS MO</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>617 PINE</i>		d. STREET ADDRESS (If outside, give location) <i>617 PINE</i>	
3. NAME OF DECEASED (Type or print) <i>GEORGE RIESTER JR</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>18</i> Year <i>1957</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 5 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TAVERN OPERATOR</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Missouri</i>
13a. FATHER'S NAME <i>GEORGE RIESTER SR</i>		13b. MOTHER'S MAIDEN NAME <i>LOUISA BLAIR</i>	14. NAME OF HUSBAND OR WIFE <i>NONE</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>ANDY KADLEZ 3505 UTAH</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Nono pericardium</i> DUE TO (b) <i>Ruptured Heart</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.1</i>			INTERVAL BETWEEN ONSET AND DEATH
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.)	
20c. TIME OF INJURY Hour _____ g.m. _____ p.m. _____		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	
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <i>810 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE <i>Patrick Taylor Carson</i> (Degree of title)		21b. ADDRESS <i>1300 Clark</i>	
22a. DATE SIGNED <i>11.18.57</i>		22b. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>Nov. 20 1957</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS MO</i>	
24. FUNERAL DIRECTOR <i>Thomas Kates 2906 Lewis</i>		25. DATE RECD. BY LOCAL REG. <i>NOV 18 57</i>	
26. REGISTRAR'S SIGNATURE <i>Carl Smith mo</i>		27. ADDRESS <i>mo</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Samuel Dill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Havana*

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.