

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1958

3498  
STATE FILE NUMBER  
916

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

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>25 St. Louis City Hospital #1</b>		Length of stay in 1b <b>2 Weeks 26</b>	d. STREET ADDRESS <b>2107 N. Wharf</b>
3. NAME OF DECEASED (Type or print) <b>Christopher Riker</b>		4. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>Alton, Illinois</b>
13a. FATHER'S NAME <b>Abraham Riker</b>		13b. MOTHER'S MAIDEN NAME <b>Lucinda Scott</b>	14. NAME OF HUSBAND OR WIFE <b>June Riker</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>190-14-5899</b>	17. INFORMANT Address <b>Mrs. June Riker 2107 N. Wharf</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE SUPPURATIVE PAROTITIS</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>CHOREA DUE TO CEREBRAL ARTERIO SCLEROSIS</b> DUE TO (c) <b>GENERALIZED ARTERIO SCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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.) <b>537X</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.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 <b>1/10/58</b> to <b>Jan. 23, 1958</b> and last saw <sup>for</sup> him <sup>alive</sup> on <b>Jan. 23, 1958</b> Death occurred at <b>5:25 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Walter H. Surfat</i> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>1515 Lafayette Ave.</b>	22c. DATE SIGNED <b>1/24/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Jan. 27, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Jefferson Bks. Mo.</b>
24. FUNERAL DIRECTOR <b>Hoffmeister U &amp; L Co.</b> ADDRESS <b>781 S. Broadway</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 25 '58</b>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith Mo</i> <b>mXB</b>

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.

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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.

### 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 *Bill C. Branson* .....

DEPT. OF HEALTH

DEPT. OF HEALTH

DEPT. OF HEALTH

Licensed Embalmer No. *4769* .....

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.