

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**58-046597**  
STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3224

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. LOUIS</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>CLAYTON</b>   |  | c. CITY OR TOWN <b>ST. LOUIS</b>  |  |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| 4/6 FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>COUNTY HOSPITAL</b>  |  | Length of stay in 1b <b>76 DAYS 2079</b>  |  |
| d. STREET ADDRESS <b>4891 SANFRANCISCO</b>  |  | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>              |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Fred</b> Middle <b>Riethmaier</b> East  |  | 4. DATE OF DEATH <b>Dec. 9-8-1958</b>   |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>July 22, 1884</b>   |  |
| 9. AGE (In years last birthday) <b>74</b>   |  | IF UNDER 1 YEAR Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ELECTRICIAN</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>COMMERCIAL</b>   |  |
| 11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>   |  |
| 13a. FATHER'S NAME <b>JACOB RIETHMAIER</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>MARIE MESH</b>   |  |
| 14. NAME OF HUSBAND OR WIFE <b>SARAH RIETHMAIER</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>NO</b>  |  | 16. SOCIAL SECURITY NO. <b>488-07-1374</b>  |  |
| 17. INFORMANT <b>SARAH RIETHMAIER</b>   |  | Address <b>4891 SANFRANCISCO</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR HEMORRHAGE</b>  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>CEREBRAL ARTERIO-SCLEROSIS</b>  |  |   |  |
| DUE TO (c) <b>HYPERTENSION. 331X</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>GENERALIZED ARTERIO-SCLEROSIS.</b>  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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.)<br><b>conv. by affluence</b>    |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |  | <b>2/11-58</b>  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <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>12-2-58</b> to <b>12-9-58</b> and last saw him alive on <b>12-8-58</b><br>Death occurred at <b>10:05</b> A. m. on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |  |
| 22a. SIGNATURE <b>N. B. Kelley</b> (Degree or title) <b>M.D.</b>  |  | 22b. ADDRESS <b>601 S. Brentwood, Clayton, Mo</b>   |  |
| 22c. DATE SIGNED  |  |   |  |
| 23. BURIAL CEMETERY <b>BURIAL</b>   |  | 23a. DATE <b>DEC. 12, 1958</b>  |  |
| 23b. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>  |  | 23c. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MISSOURI</b>  |  |
| 24. FUNERAL DIRECTOR <b>STROOT CARROLL</b> ADDRESS <b>4600 NATURAL BRIDGE</b>   |  | 25. DATE RECD. BY LOCAL REG. <b>12-10-58</b>  |  |
| 26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>  |  |   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *M W Rueter* .....

Licensed Embalmer No. *4865* .....  
P. O. Address *St Louis Mo.* .....

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.