Health, Welfare Public Service

300 0 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-047269
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12655

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 (If outside corporate limits, give TOWNSHIP only) ST. LOUIS — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN ~~ST. LOUIS~~ 4000 0 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) CHRISTIAN HOSPITAL — Length of stay in Ib	d. STREET ADDRESS (If outside, give location) 10810 MC DUFF DRIVE — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
KATHLEEN	DIANE	RIESE	DEC.	28	1958

5. SEX	6. COLOR OR RACE	7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		DEC. 28 1958				7	11

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
NONE		ST. LOUIS MISSOURI	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
LESTER RIESE	HELEN MITCHELL	NONE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	**********	NONE	MRS. HELEN RIESE	10810 MC DUFF DRIVE

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Prematurity

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) premature rupture of membranes

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 761.5

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 12-28-58, to 12-28-58 and last saw her/him alive on 12-28-58

Death occurred at 1:10 pm on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Kenneth V Larsen MD	6079 N. Grand Ave.	12-30-58

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
REMOVAL	DEC. 31 1958	NEW BETHLEHEM CEMETERY	ST. LOUIS COUNTY MISSOURI

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
BEIDERWIEDEN F.H.INC,	1936 ST.LOUIS AVE	DEC 30 '58	J Carl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

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 Homer W. Fritz

Licensed Embalmer No. 3882

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.