

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015609

STATE FILE NUMBER

2 4025

Registration District No. _____ Primary Registration District No. _____

FILED MAY 11 1959

300

-57

26

84

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPR. #1		Length of stay in 1b		d. STREET ADDRESS 2330 Olive St.	
3. NAME OF DECEASED (Type or print) First FRED Middle J. Last Riesenbeck		4. DATE OF DEATH		Month Day Year APRIL 23, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1886	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Government Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Herman D. Riesenbeck		13b. MOTHER'S MAIDEN NAME Katherine A. Abel	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 567-38-5618	
17. INFORMANT Address William J. Riesenbeck 3160 Leola		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Failure		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) Arteriosclerotic Heart Disease		DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY		Hour Month, Day, Year a.m. p.m.		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		20g. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at		2/ 4/59 to 4/23/59		and last saw her him alive on 4/23/59	
22a. SIGNATURE (Degree or title) Samuel W. Handy Jr. M.D.		22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 4/23/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Apr. 27, 1959		23c. NAME OF CEMETERY OR CREMATORY National Cemetery	
23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.		24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. APR 24 '59	
25. REGISTERAR'S SIGNATURE Roald Smith. M.D. C.P.					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *William B White*

Licensed Embalmer No. *4281*

P. O. Address *228th Street*

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.