

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-013130**

**FILED VS MAR 24 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 2848** STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (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>	Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3931 Lafayette Ave.,</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3931 Lafayette Ave.,</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <b>HENRY</b> Middle <b>RIEKE</b> Last			<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>9</b> Year <b>1960</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1-21-78</b>	<b>9. AGE</b> (last birthday) <b>82</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Trimmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Casket</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
<b>13a. FATHER'S NAME</b> <b>(Unknown) Rieke</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Late Alma E. Rieke</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>None</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>	<b>17. INFORMANT</b> Address <b>Edna Macomber, 3931 Lafayette Avenue</b>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Yentricular fibrillation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>57 min</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>P. S. A. D.</i>		<i>57 min.</i>
	DUE TO (c) <i>4200</i>		

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)		<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. _____	Month, Day, Year		
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b> _____ <b>STATE</b> _____

**21. I attended the deceased from** *1/26/60*, to *3/9/60*, and last saw her *3/9/60* alive on *3/9/60*.  
Death occurred at *7:34 p.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <i>D.E. Beckman M.D.</i>	(Degree or title)	<b>22b. ADDRESS</b> <i>4205 Virginia</i>	<b>22c. DATE SIGNED</b> <i>3/10/60</i>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>3-12-60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Friedens Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) <b>St. Louis, Missouri</b>
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<b>24. FUNERAL DIRECTOR</b> <b>CALVIN F. FRUTZ, 4828 Natural Bridge Blvd,</b> <b>FUNERAL HOME, St. Louis, 15, Missouri.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>MAR 11 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Earl Smith M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ralph C. Linders

Licensed Embalmer No. 4275

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.