

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040501

FILED VS. OCT 24 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3009 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in lb <u>19 Day's</u>	c. CITY OR TOWN <u>Wellston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1400 Odgen Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>RISCHECK</u> Last <u>RISCHECK</u>	4. DATE OF DEATH Month <u>10</u> - Day <u>15</u> - Year <u>60</u>
--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/18/1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
--------------------	-------------------------------	--	-----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	---	---	--

13a. FATHER'S NAME <u>Gustave Rischeck</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Vortisch</u>	14. NAME OF HUSBAND OR WIFE <u>Divorced</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>497 01 7703</u>	17. INFORMANT <u>Fridea Delaney</u>	Address <u>3317 Lawn Ave</u>
--	---	--	---------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	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. <u>Subacute bacterial endocarditis</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

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.)
---	---	--

20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.	Month, Day, Year
---	------------------

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 9-26-60 to 10-15-60 and last saw him alive on 10-15-60
Death occurred at 11:55 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Albert P. Howe M.D.</u> (Degree or title)	22b. ADDRESS <u>601 S. Brentwood, Clayton</u>	22c. DATE SIGNED <u>10/16/60</u>
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/18/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Ann, Mo.</u>
--	--------------------------------	---	--

24. FUNERAL DIRECTOR <u>Collier Mortuary, St. Ann, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-17-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
---	---	---

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 Sheldon Collier

Licensed Embalmer No. 338

P. O. Address St. Am

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