

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046783

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11778 STATE FILE NUMBER

FILED DEC 21 1961

1. PLACE OF DEATH a. COUNTY		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>Saint Louis</u>		Length of stay in 1b <u>3 months</u>	c. CITY OR TOWN <u>Bel Ridge</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4255 Springdale Dr.</u>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Riedel</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/96</u>	9. AGE (last birthday) <u>65 yrs</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Post Dispatch</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Robert L. Riedel</u>	13b. MOTHER'S MAIDEN NAME <u>Catherine Windler</u>	14. NAME OF HUSBAND OR WIFE <u>Lucy Riedel</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.#1</u>	17. INFORMANT Address <u>Mrs. Lucy Riedel, 4255 Springdale Dr. 34</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Organic brain disease</u> DUE TO (b) <u>Generalized arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>422.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic osteomyelitis right hip</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ 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 _____
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21. I attended the deceased from <u>2-25-59</u> to <u>12-17-61</u> and last saw her/him alive on <u>12-17-61</u> Death occurred at <u>11:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>C. E. Mueller M.D.</u>	22b. ADDRESS <u>634 N. Grand Blvd.</u>	22c. DATE SIGNED <u>12-18-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/20/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bt. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>CALVIN F. FEUTZ, 4828 Natural ridge Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 18 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2 30 }
9 30 }
3 30 }
11 }
4 }
John
man

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Robert E. Mableman

Licensed Embalmer No. 4916

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.