

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046789

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11792** STATE FILE NUMBER

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Length of stay in lb 12 hrs	c. CITY OR TOWN Crestwood	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9201 Watson Road	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First PETER Middle FREDERICK Last RISCHER			4. DATE OF DEATH Month December Day 18 Year 1961			
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-9-89	9. AGE (last birthday) 72	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool and Die Maker		10b. KIND OF BUSINESS OR INDUSTRY Tool Industry	11. BIRTHPLACE (City and state or country) Westphalia, Germany		12. CITIZEN OF WHAT COUNTRY U.S.A. (Nat.)	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Emma Berner Rischer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			17. INFORMANT Mrs. Emma Rischer Address 9201 Watson Rd. Crestwood, Missouri			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETIC ACIDOSIS		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) DIABETES		UNKNOWN
	DUE TO (c) 260xH		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHROMIC LYMPHATIC LEUKEMIA		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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.)	
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

21. I attended the deceased from **EARLY, 1961** to **12-18-61** and last saw ^{her}him alive on **12-18-61**
Death occurred at **4 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Milton Kardesch, M.D.	22b. ADDRESS 9293 Highway 66 St. Louis 26, Mo.	22c. DATE SIGNED 12/18/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec 20, 1961	23c. NAME OF CEMETERY OR CREMATORY Mount Hope	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR ADDRESS HOFFMEISTER COLONIAL MORTUARY 6464 Chippewa, St. Louis	25. DATE RECD. BY LOCAL REG. DEC 18 1961	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

State of Missouri

Sanitary

Department

Health

X

City of St. Louis

19

1918

Name of deceased

Age

Sex

Place of death

Time of death

Cause of death

Signature of licensed embalmer

Signature of student embalmer

Signature of physician

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 Bill C. Branson

Licensed Embalmer No. 4764

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.