

Registration District No. 791

Primary Registration District No. _____

Registrar's No. 10141

1. PLACE OF DEATH: 1003
 (a) County St Louis
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Lutheran Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Catherine Rist 230

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Gottlieb Rist 6. (c) Age of husband or wife if alive 1864 years

7. Birth date of deceased April 20 1864
 (Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 60 If less than one day hr. _____ min. _____

9. Birthplace Germany
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Martin Manners

18. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Anna Birken

15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lillian Rist
 (b) Address 3223 North 20th St

17. (a) Burial (b) Date thereof Nov 29 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cem

18. (a) Signature of funeral director Beiderwieden Funl Home
 (b) Address 1936 St. Louis Ave

19. (a) NOV 28 1939 (b) J. J. Beck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 1
 (c) City or town St Louis 26
 (If outside city or town limits, write "RURAL")
 (d) Street No. # 3223 North 20th St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 November day 26
 year 1939 hour 11:25 minute P M.

21. I hereby certify that I attended the deceased from October 20
39, to 11-26-39, 19____;
 that I last saw her alive on 11-26-39, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death By laceration of stomach

Due to Chronic Cholecystitis

Due to _____

Other conditions Diabetes mellitus
 (Include pregnancy within 9 months of death)

Major findings: Severe scarring be-
forever gall bladder &
 Of autopsy By lacer.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

In _____ while at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Thos H. Huser (M. D. or other) _____

Address 3657 Grand St Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed: *Delis J. Kripin*
Licensed Embalmer No. *3497*
P. O. Address *1936 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 this body is not embalmed, above space should be left blank.