

No. 2
1-10-39
-17-39
-23-092

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33182 ✓

State File No. _____

Registration District No. 184

Primary Registration District No. 117

Registrar's No. 1681

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town WEBSTER GROVES
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
685 CLARK
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20
(Specify whether
In this community 22 YRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS
(c) City or town WEBSTER GROVES
(If outside city or town limits, write "RURAL")
(d) Street No. 685 CLARK AVE.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME WILLIAM PORTER RIED

3. (b) If veteran, name war None 3. (c) Social Security No. 493-09-7269

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LOUISE NORTH RIED 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased JULY 6th - 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>1</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation DEPT MANAGER

11. Industry or business SHAPLEIGH HWDE CO.

12. Name JOSEPH RIED

13. Birthplace SPRINGFIELD OHIO
(City, town, or county) (State or foreign country)

14. Maiden name FLORENCE OSBORN

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

16. (a) Informant Louise North Ried

(b) Address 685 CLARK AVE W. G.

17. (a) BURIAL (b) Date thereof SEPT. 5-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK HILL CEM.

18. (a) Signature of funeral director Parker and Co
(b) Address Webster Groves Mo

19. (a) SEP - 5 1940 (b) W. R. Meyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept - day 4 -
year 1940 hour 12 minute 2 M.

21. I hereby certify that I attended the deceased from Aug 10-40
1940 to _____ 19 ;

that I last saw him alive on Aug - 30 1940
and that death occurred on the date and hour stated above.

Immediate cause of death sloughation coronary artery

Due to sloughation coronary vessels

Due to None

Other conditions Practical asthma
(Include pregnancy within 3 months of death)

Major findings: 5-illness pulmonary tuberculosis
Of operations (None) X-ray of chest June 15 - 1940

Of autopsy None

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

(a) Accident, suicide, or homicide (specify) None

(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?
707

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

23. Signature Frank A. ... (M. D. or other)

Address 17 E. ... Date signed 8/5/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 C. C. Aldrich

Licensed Embalmer No. 1332

P. O. Address Webster Groves

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.