

FILED JUN 13 1948

Registration District No. 5184

Primary Registration District No. 5184

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: Entire Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME IDA STATLER RIEHN

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 married
6. (b) Name of husband or wife Odes Riehn 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased April 13-1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 0 23 hr. min.

9. Birthplace near Millersville (City, town, or county) (State or foreign country) Mo 0

10. Usual occupation Housekeeper

11. Industry or business

12. Name Jacob Statter
13. Birthplace Daisy (City, town, or county) (State or foreign country) Mo 0
14. Maiden name Mary Tucker
15. Birthplace Daisy (City, town, or county) (State or foreign country) Mo 0

16. (a) Informant Norton C. Riehn
(b) Address Edge Girardeau Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Old Glen

18. (a) Signature of funeral director J. H. G. ...
(b) Address Jackson
19. (a) May 7, 1948 (Date received, local registrar) (b) J. H. G. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5th day 6th year 1943 hour 3 minute A.M.
21. I hereby certify that I attended the deceased from 5-3-1943 to 5-6-1943
that I last saw h. alive on 5-3-1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy (Ht.)
Due to Chronic Hypertension
Vascular sclerosis
Due to Chronic parenchymatous nephritis
Diabetes
Other conditions (Include pregnancy within 3 months of death) Diabetes

Major findings: 131f
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) V
(b) Date of occurrence V
(c) Where did injury occur? V (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? V

While at work? (Specify type of place)
(e) Means of injury V
23. Signature Alfred M. ... (M. D. or other) Phys
Address Jackson Mo Date signed 5-6-43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4
District File Number 643-2287
Date Filed 6-7-43

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 Gene C. Cracraft

Licensed Embalmer No. 4327

P. O. Address Jackson, 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 this body is not embalmed, fact should be so stated above.