S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

9392

State File No.

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 2919

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 709a Carroll
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) 68
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 709a Carroll St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LUCINDA RIES
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife William Ries
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased May 16 (Month) 1857 (Day) (Year)
8. AGE: Years 86 Months 10 Days 11 If less than one day hr. min.
9. Birthplace St Mary, Ste Genevieve Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation housewife
11. Industry or business At home
12. Name of father John Renner
13. Birthplace St Mary, Ste Genevieve Co Mo (City, town, or county) (State or foreign country)
14. Maiden name of mother Lillie Brown
15. Birthplace St Mary, Ste Genevieve Co Mo (City, town, or county) (State or foreign country)
16. (a) Informant William Ries
(b) Address 709a Carroll St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30-1944 (Month) (Day) (Year)
(c) Place: Burial or cremation Ste Marcus Cem
18. (a) Signature of director Henry L Weidemueller
(b) Address 3727 Gravois Ave
19. (a) MAR 29 1944 (Date received local registrar) (b) J. F. Bredesh (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27 year 1944 hour 4 minute - P.M.
21. I hereby certify that I attended the deceased from March 1 1944 to March 27 1944 that I last saw her alive on 3/26 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocarditis	1 day
Due to Cerebral Thrombosis	20 days
Due to Cerebral Arteriosclerosis	2 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury
(f) Signature Edw H Ferman (M.D. or other)
Address 2924 S Grand Blvd Date signed 3/28/44

844

(Licensed Embalmer's Statement on Reverse Side)

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 John Ogonoski

Licensed Embalmer No. 3398

P. O. Address.....

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.