

FILED NOV 25 1946

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

9669

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.
 (b) City or town St. Louis, Missouri.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME ELLA RIESTER

3. (b) If veteran, name war Nil
 3. (c) Social Security No. 491-18-3862

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased October 13 1882
 (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>64</u> | <u>0</u> | <u>29</u> | _____ hr. _____ min. |

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

10. Usual occupation Hairdresser

11. Industry or business _____

MOTHER FATHER { 12. Name Valentine Riester

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

14. Maiden name Mary Bermen

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

16. (a) Informant Walter Riester
 (b) Address 414 N. 12th St.

17. (a) Burial (b) Date thereof 11-14-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem.
Fred M. Williams

18. (a) Signature of funeral director _____
 (b) Address 4535 Washington Blvd.

19. (a) NOV 13 1946 J. F. Brink
 (Date received local registrar) (Registrar's signature)

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. 4396 Olive St.
Memorial (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12th
 year 1946 hour 9:15 minute _____ A. M.

21. I hereby certify that I attended the deceased from 11/3/46
 to Nov. 12th 19 46
 that I last saw her alive on Nov. 12th 19 46
 and that death occurred on the date and hour stated above.

Immediate cause of death:
1) Carcinoma of liver
2) Carcinoma of pancreas
3) Pulmonary Tuberculosis, MA
 Duration _____ years
 Due to _____

Other conditions: _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy Same as above
 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? _____

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

23. Signature Robert J. Starkloff Date signed 11/12/46
 Address _____ Date signed _____

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.....

John S. Kennedy

Licensed Embalmer No. *4194*

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.