

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

3989

State File No. ....

FILED MAR 1 1954

BIRTH NO. ....		REG. DIST. NO. <u>38</u>	PRIMARY REG. DIST. NO. <u>5120</u>	Registrar's No. <u>57</u>
1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, write RURAL and give town) <u>Columbia</u>		c. LENGTH OF STAY (In this place) <u>40 yrs</u>	c. CITY OR TOWN <u>Columbia</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Route #3e1 Mi. West.</u>		e. STREET ADDRESS (If rural, give location) <u>Mike West. Columbia</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u>		b. (Middle) <u>C</u>	c. (Last) <u>Riechmann</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 18, 1954</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 2, 1881</u>	9. AGE (In years less birthday) <u>75</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Charles Riechmann</u>		13b. MOTHER'S MAIDEN NAME <u>Christena ?</u>		14. NAME OF HUSBAND OR WIFE <u>Caroline Riechmann</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME <u>Clarence Riechmann, Columbia, Mo.</u> ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute monocytic leukemia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>none</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 mo.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Mar 28, 1953</u> , to <u>Feb. 18, 1954</u> , that I last saw the deceased alive on <u>Feb. 18, 1954</u> , and that death occurred at <u>10:20 Am.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>James Waller MD</u>		23b. ADDRESS <u>Columbia Mo.</u>		23c. DATE SIGNED <u>2-19-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 20, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 20 1954</u>	REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	25. GENERAL DIRECTOR'S SIGNATURE <u>Franklin</u> ADDRESS <u>Memorial Funeral Home, Columbia, Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 2

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 ..... Student Embalmer No. .... working under my personal supervision..

Student ..... Signature of Student Embalmer

Signed *Lyman H. Sprinkle*

Licensed Embalmer No. 4013

P. O. Address Columbia, I.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.