

No. 300  
10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 7 - 1955

State File No. **31404**  
**8684**  
Registrar's No.

BIRTH NO.		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. <b>1003</b>	Registrar's No. <b>8684</b>	
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI.</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>			e. STREET ADDRESS (If rural, give location) <b>21 Lincoln Hotel 2226 Olive St.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>FRANK</b>		b. (Middle) <b>N.</b>	c. (Last) <b>RIEKSE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>OCT. 3, 1955.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 19, 1880</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night clerk (hotel)</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Grand Rapids, Michigan</b>		12. CITIZENRY OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND/OR WIFE <b>Elsie Waitz Riekse</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-03-7250</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Elsie Riekse 4026A Shreve Ave.</b>		
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) <b>Incarcerated Inguinal Hernia with Strangulation, right</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>561.0</b>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)	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 <b>9-18-</b> , <b>1955</b> , to <b>10-3</b> , <b>1955</b> , that I last saw the deceased alive on <b>10-3-</b> , <b>1955</b> , and that death occurred at <b>5:25p</b> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Robert W. Bussell Jr. MD</b>			23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		23c. DATE SIGNED <b>10-4-55.</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Oct 6, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>		
DATE REC'D BY LOCAL REG. <b>OCT 5 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bromschwig and Son W Florissant</b>		

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

**M. J. B.** (Licensed Embalmer's Statement on Reverse Side)

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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: Robert M. Murray  
3749  
Licensed Embalmer No.....

P. O. Address St. Louis

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.