

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 29 1957

318

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State File No. 44874

Registrar's No. 11235

BIRTH NO. 98315-56 REG. DIST. NO. PRIMARY REG. DIST. NO.

1. PLACE OF DEATH

a. COUNTY
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY St. Louis

c. CITY OR TOWN Chesterfield 0
d. Is Residence within limits of a city or incorporated town? Yes No
e. STREET ADDRESS (If rural, give location) R.R.#2, BOX 374

3. NAME OF DECEASED (Type or Print)
a. (First) Joseph b. (Middle) c. (Last) Risse
4. DATE OF DEATH (Month) (Day) (Year) 12 - 6 - 1956

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH 12 - 6 - 1956 9. AGE (In years last birthday) 1 10. Hours 19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME August Theodore Risse 13b. MOTHER'S MAIDEN NAME Aline - - Doyle 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME Mrs. Aline Risse, R.R.#2, BOX 374, Chesterfield, Mo.

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.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurely cause unknown
(b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) (No the bal profun bleeding during pregnancy)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

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) 776x

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-6-1956, to 12-6-1956, that I last saw the deceased alive on 12-6-1956, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE Ralph Berg MD (Degree or title) 23b. ADDRESS 3203 S. Grand 23c. DATE SIGNED 12/8/56

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 24b. DATE Dec 8 1956 24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM 24d. LOCATION (City, town, or county) (State) ST. LOUIS Co. Mo.

DATE REC'D BY LOCAL REG. DEC 8 1956 REGISTRAR'S SIGNATURE J. Carl Smith MD 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Harrison

WRITE PLAINLY—USING 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 Student Embalmer No.

working under my personal supervision..

Student
Signature of Student Embalmer

Signed
Licensed Embalmer No. 4347

P. O. Address 2906 St. ...

Not Embalmed

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.