

FILED OCT 31 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037128

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 342

S. 300
1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ralls</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>			Length of stay in 1b <u>Few hours</u>		d. STREET ADDRESS (If outside, give location) <u>RFD #1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>MILDRED</u> Last <u>RIEFESSEL</u>						4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1958</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24, 1897</u>		9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ralls County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13a. FATHER'S NAME <u>William Cooper</u>				13b. MOTHER'S MAIDEN NAME <u>Annie Maschen</u>				14. NAME OF HUSBAND OR WIFE <u>Frederick H. Riefesel (Deceased)</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Orville Riefesel Hannibal Missouri</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterial cerebral hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>hypertension</u>										?			
DUE TO (c) <u>331X</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)										
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____													
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE		
21. I attended the deceased from _____, to _____, and last saw her alive on _____ Death occurred at <u>8:25 A.</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>A. H. Riefesel MD</u> (Degree or title)						22b. ADDRESS <u>Hannibal Mo</u>			22c. DATE SIGNED <u>10-18-58</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/20/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>				23d. LOCATION (City, town, or county) <u>Hannibal Missouri</u> (State)					
24. FUNERAL DIRECTOR <u>W. Crawford Smith, Hannibal Missouri</u> ADDRESS						25. DATE RECD. BY LOCAL REG. <u>10-22-1958</u>		26. REGISTRAR'S SIGNATURE <u>W. C. Fisher</u>					

RECEIVED OCT 28 1958
MARION CO. HEALTH DEPT.
DATE FILED OCT 28 1958

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 John S. Stang

Licensed Embalmer No. 4540.....

P. O. Address Hannibal Missouri

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.