ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

61-020405
STATE FILE NUMBER

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 390

FILED JUN 26 1961

1. PLACE OF DEATH
a. COUNTY Boone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia
Length of stay in 1b: 3 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION University of Missouri Medical Center
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Miller
c. CITY OR TOWN Lake Ozark
Inside Limits: Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) None
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Monroe Middle Constance Last Riek
4. DATE OF DEATH: Month 6 Day 17 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☑
8. DATE OF BIRTH: 8-9-1893
9. AGE (last birthday): 67
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (City and state or country): Hermann, Mo
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Constance Riek
13b. MOTHER'S MAIDEN NAME: Clara Hickmann
14. NAME OF HUSBAND OR WIFE: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1917 – 1919
17. INFORMANT: University of Missouri Medical Records Address: Columbia, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic glomerulonephritis — ?
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Pyelonephritis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 6-17-61 to 6-17-61 and last saw him alive on 6-17-61
Death occurred at 4:15 Pm on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Morris Gordon M.D.
22b. ADDRESS: Univ. Hosp. Columbia Mo
22c. DATE SIGNED: 6-17-61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6-17-1961
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson City, Missouri
24. FUNERAL DIRECTOR: Gideon N. Houser ADDRESS: Jefferson City, Mo.
25. DATE RECD. BY LOCAL REG.: June 29, 1961
26. REGISTRAR'S SIGNATURE: Mrs R E Palmer

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1961 22 NOV SA

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 Bill McLaughlin, Student Embalmer No. 620

working under my personal supervision.

Student Bill McLaughlin Signed Gideon N. Houser
Signature of Student Embalmer

Licensed Embalmer No. 4579

P. O. Address Jefferson City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.