

MISSOURI DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017189

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **4042** STATE FILE NUMBER

FILED APR 25 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2904 Geyer Ave.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2904 Geyer Ave.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First ALBERT Middle Last RIST, SR.			4. DATE OF DEATH Month April , Day 17 , Year 1962			5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Apr. 11, 1872		9. AGE (last birthday) 90 years		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) Retired Dry Goods Merchant				10b. KIND OF BUSINESS OR INDUSTRY Merchant				11. BIRTHPLACE (City and state or country) Germany				12. CITIZEN OF WHAT COUNTRY U. S. A.							
13a. FATHER'S NAME Leopold Rist				13b. MOTHER'S MAIDEN NAME Katherine Spechy				14. NAME OF HUSBAND OR WIFE Hulda Rist											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No war.						17. INFORMANT Address Mrs. Elsie R. Duggar, 2904 Geyer Ave.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4201 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																			
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 _____ a.m. _____ p.m.		Month, Day, Year																	
20d. INJURY OCCURRED WHILE AT WORK <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 5/7/60 to 4/12/62 and last saw her/him alive on 4/16/62 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)						22b. ADDRESS 3012 Lafayette Park			22c. DATE SIGNED 4/18/62										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)											
Removal		April, 20, 1962		N. St. Marcus Cemetery				St. Louis Co. Missouri											
24. FUNERAL DIRECTOR Witt Mortuary, 6409 Gravois Ave. St. Louis.				25. DATE RECD. BY LOCAL REG. APR 18 1962		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>													

VS 300 Rev. 4/59
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DATE AMENDED
2/17/62
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
90
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DR. Tirof. Letti
3012 Lafayette

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 Harvey Kelle

Licensed Embalmer No. 4596

P. O. Address St. Louis, Mo

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.