

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

63-030435

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7758

FILED AUG 1 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis,	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Length of stay in 1b 7 years	c. CITY OR TOWN Bel-Ridge Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anne Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4255 Springdale Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE MARGARET RIEDEL	4. DATE OF DEATH Month Day Year July 27, 1963
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5. SEX Female	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 8-12-1872	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Claus Windeler	13b. MOTHER'S MAIDEN NAME Lena Michaelis	14. NAME OF HUSBAND OR WIFE Robert Riedel, deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	17. INFORMANT Address Katherine Kaune, 6923 Glenmore Avenue
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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>Arteriosclerotic heart disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>420.0</u>	INTERVAL BETWEEN ONSET AND DEATH ?
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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
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21. I attended the deceased from 5-31-60 to 7-27-63 and last saw her ^{her} alive on 7-2-63 Death occurred at 7:20 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>C. E. Mueller, M.D.</i>	22b. ADDRESS 634 N. Grand Blvd.	22c. DATE SIGNED 7-29-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 31, 1963	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Missouri
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24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ, 4828 Natural Bridge Bl.	25. DATE RECD. BY LOCAL REG. JUL 29 1963	26. REGISTRAR'S SIGNATURE <i>Loal Smith, M.O.</i>
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27. AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
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28. DATE AMENDED	29. DATE RECD. BY LOCAL REG.
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DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 - Rev. 4/59

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Dr. C. E. Mueller
Missouri Thea. Bldg.
JE 3-7469

HOURS: Monday, 2:30 to 6 PM
Tuesday, 9:30 to 11 AM
2:30 to 4 PM

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 E. Mullen

Licensed Embalmer No. 4916

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.