

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 2
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
316 Geyer Ave.,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME John Dielschneider 425
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Elizabeth Dielschneider 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 18, 1859
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Blacksmith

11. Industry or business _____

12. Name John Dielschneider

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Bink

(b) Address 317 Lenhardt St. Louis County

17. (a) Burial (b) Date thereof Dec. 2, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S.S. Peter and Paul Ch.

18. (a) Signature of funeral director Weick Bros. Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) DEC 1 1939 (b) _____
(Date received local registration)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
(d) Street No. 316 Geyer Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 29
year 1939 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from 7
Nov. 20, 1939, to Nov 29, 1939
that I last saw h. _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocarditis
Chronic Interstitial Nephritis

Duration

2 yrs
2 yrs

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. B. Kern (M. D. or other) M. D.

Address 2002 So. Broadway Date signed 12/1/39

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Wm. A. Stewart

Licensed Embalmer No..... 3722

P. O. Address..... 412 Duchouquette St.

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 this body is not embalmed, above space should be left blank.