

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **15919**

Registration District No. **757** Primary Registration District No. **3036** Registrar's No. **71**

1. PLACE OF DEATH:
 (a) County St. Charles
 (b) City or town St. Charles
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community One & 1/2 Day (Specify whether)
 years, months or days

3. (a) PRINT FULL NAME Lucas Bernard Dieckhaus
8. (b) If veteran, name war No **3. (c) Social Security** No. No

4. Sex Male **5. Color or race** White **6. (a) Single, widowed, married, divorced** Married
6. (b) Name of husband or wife Wilhelmina Philman **6. (c) Age of husband or wife if alive** 62 years
7. Birth date of deceased October 19 1875
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>6</u>	<u>11</u>	hr. _____ min. _____

9. Birthplace Dutzow Mo.
 (City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer

11. Industry or business
12. Name Bernard Dieckhaus
13. Birthplace Augusta Mo.
 (City, town, or county) (State or foreign country)
14. Maiden name Lena Kappmann
15. Birthplace Augusta Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Wilhelmina Dieckhaus
(b) Address 1415 N. Third, St. Charles, Mo.
17. (a) Burial **(b) Date thereof** May 1 - 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cossamer Cem. St. Charles

18. (a) Signature of funeral director H. C. Dellmeyer & Sons Co.
(b) Address 800 N. Second, St. Charles, Mo.
19. (a) 5/1/40 **(b)** Clarence H. Hessler
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Charles
 (c) City or town St. Charles
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1415 N. Third St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 29
 year 1940 hour 2 minute 55 P.M.
21. I hereby certify that I attended the deceased from 4-10-40
4-29-40, 1940, to _____, 19____;
 that I last saw him alive on 4-29- _____, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chr myocarditis

Due to _____
 Due to _____

Other conditions Chr nephritis
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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? 179

23. Signature R. J. Budice (M. D. or other) _____
 While at work? _____ (Specify type of place) _____
 (e) Means of injury _____
Address 701 Clay St **Date signed** 5/2/40

Duration 5 yrs
 5 yrs
PHYSICIAN
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *John E. Dallmeier*

Licensed Embalmer No. *2951*

P. O. Address *St Charles 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 this body is not embalmed, above space should be left blank.