

FILED APR 17 1943  
Registration District No. 224

Primary Registration District No. 3046

1. PLACE OF DEATH

(a) County Placer  
(b) City or town California  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution one year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Montgomery  
(c) City or town California  
(If outside city or town limits, write "RURAL")  
(d) Street No.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Oscar William Diehl

3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Louise Diehl  
6. (c) Age of husband or wife if alive 15 years (Month) (Day) (Year)  
7. Birth date of deceased Oct 15 1905

8. AGE: Years 37 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Cooper Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

12. Name Theodore Diehl Co  
13. Birthplace Cooper Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Evelyn Kaiser  
15. Birthplace Cooper County Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Oscar Diehl  
(b) Address California  
17. (a) Burial (b) Date thereof Pleasant Grove  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Pleasant Grove

18. (a) Signature of funeral director William F. Friedmeyer  
(b) Address California Mo  
19. (a) 3-10-43 (b) H. J. Allee  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month March day 8th  
year 1943 hour 4 minute 0 P. M.

21. I hereby certify that I attended the deceased from Oct. 29, 1943 to March 8, 1943  
that I last saw him alive on March 25, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Intra-Cranial  
hemorrhage from aneurysm

Due to Intra-cranial tumor

Due to

Other conditions (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?

23. Signature O. P. Burt (M. D. or other)  
Address California, Mo Date signed 3/8/43

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

W. H. J. BE. J. B. D.

MAY 2 1961

**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 *Hugh E. Wellman*

Licensed Embalmer No. *3537*

P. O. Address *California 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10906  
Registrar's No. 75

Registration District No. 224 Primary Registration District No. 3046

1. PLACE OF DEATH:

(a) County Moniteau  
(b) City or town California  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Oscar Wm Diehl

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Oct 14 1903  
(Month) (Day) (Year)

8. AGE: Years 37 Months 4 Days \_\_\_\_\_ (If less than one day \_\_\_\_\_) min.

9. Birthplace mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day \_\_\_\_\_ year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death intracranial hemorrhage  
embolus

Due to Cerebrovascular compression

Due to intracranial tumor, 3rd ventricle, calcification

Other conditions of pituitary gland - x-ray shows separation of chiasm and anterior pituitary gland -  
(Include pregnancy within 3 months of death)  
of operations

convulsions during  
show other evidences of disturbance of autops.  
para. thyroid activity

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) (c) Means of injury \_\_\_\_\_

23. Signature J. P. Burke (M. D. or other) \_\_\_\_\_

Address California, Mo Date signed 4/30

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-10906