

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis Mo

(c) Name of hospital or institution: Alexian Bro. Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 Days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Henty Diedrich

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 489-18-9130

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Sept. 9 1858  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>4</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation Retired Harness Maker

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Adolph Diedrich

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

14. Maiden name Catherine Kaiser

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

16. (a) Informant William Diedrich

(b) Address 2816 Lemp Ave

17. (a) Burial (b) Date thereof Jan 24/ 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter & Paul

18. (a) Signature of funeral director John H. Luther Sang

(b) Address 2630 Gravois Ave

19. (a) JAN 23 1945 J. F. Brudick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 2816 Lemp Ave  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20 year 1945 hour 6:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to JAN. 20 1945

that I last saw him live alive on JAN. 20 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Myocardial Infarction

Due to Fracture of Hips

Due to Chronic Myocarditis

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Duration 3 year

Major findings: Of operation Fracture of Femur "Surgical Neck"

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes by the following:

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

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? at his home; Fall on floor.  
(City or town) (County) (State)

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

(e) What work? None (Specify type of place)

(f) Means of injury Fall on floor

23. Signature A. Julius De Rater (M. D. or other) \_\_\_\_\_

Address 2603 Elmwood St. Date signed 1-22-45

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..... *Robert J Gebken* .....

Licensed Embalmer No..... 4144 .....

P. O. Address..... 2630 Gravois Ave .....

**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.**