

No. 2
-2-43
5-17-39
X35697

FILED JUN 7 1945
Registration District No. 327

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis.

(b) City or town Richmond Heights.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days.
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County St. Louis.

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. Conway & Ballas Roads.
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME KATHRYN P. DEIBEL.

3. (b) If veteran, name war None.

3. (c) Social Security No. None.

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

6. (b) Name of husband or wife Robert F. Deibel, 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 28, 1884.
(Month) (Day) (Year)

8. AGE: — Years Months Days If less than one day

60. 8. 12. hr. _____ min.

9. Birthplace Chicago, Illinois!
(City, town, or county) (State or foreign country)

10. Usual occupation At Home.

11. Industry or business _____

12. Name George Plamondon.

13. Birthplace Chicago, Illinois!
(City, town, or county) (State or foreign country)

14. Maiden name Kathryn Coughlin.

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

16. (a) Informant Mrs Kathryn Lungstras.

(b) Address Gatesworth Hotel.

17. (a) Burial. (b) Date thereof 5/12/45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hiram Cemetery.

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Bl'vd.

19. (a) MAY 14 1945 (b) E. E. H. P. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May. day 10th,
year 1945. hour 6:20 minute _____ P. M.

21. I hereby certify that I attended the deceased from June 10, 1945 to May 10, 1945
that I last saw her alive on May 10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarct Duration 2 days

Due to Pneumococcus Type T pneumonia + bacteremia 3 days

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

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 Edith Kramer (M. D. or other) M.D.

Address 634 N. Grand Date signed 5-11-45

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

Dr Fred Kramer,
634 N. Grand Ave.,
JE: 1870.
Hrs: 1 - 3.

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.....

J. J. Lupton

Licensed Embalmer No. *3122*

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 this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 317 Primary Registration District No. 3069 Registrar's No.

1. PLACE OF DEATH:

- (a) County St Louis
 (b) City or town Richmond Heights
 (If outside city or town limits, write "RURAL" and name of township)
 (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. (Specify whether

In this community _____
years, months or days)3. (a) PRINT FULL NAME Kathryn P. Deibel

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

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced Wid
 race _____

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

7. Birth date of deceased Aug 28 1947
 (Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day
 hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
 (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 19
 year 1947 hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ 19____;
 to _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____

Due to Lobar Pneumonia

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 108

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 Ed Kramer (M. D. or other) _____Address 634 N. Grand Ave Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

18051