S. No. 2
M—2-43
. 5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38457

FILED NOV 26 1945

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2636

1. PLACE OF DEATH:

(a) County: St Louis

(b) City or town: Manchester (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Manchester Nursing Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: St Louis 96

(c) City or town: Manchester (If outside city or town limits, write "RURAL") 0

(d) Street No. ____ (If rural, give location) 0

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME: Judith Ann Diehl

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: Nov. (Month) 12 (Day) 1945 (Year)

8. AGE: Years ____ Months ____ Days 5 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Nil

11. Industry or business ____

FATHER
12. Name: Melvin Diehl
13. Birthplace: St Louis (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name: Helen Gray
15. Birthplace: St Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Mr. Melvin Diehl
(b) Address: 7412 Canton Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Hill Cem

18. (a) Signature of funeral director: Louis H. Beffano
(b) Address: Kirkwood Mo.

19. (a) 11-20-45 (Date received local registrar) (b) E. B. McDermott M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17 year 1945 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from Nov. 14, 1945, to Nov 15, 1945; that I last saw her alive on Nov. 16, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Inanition	5 days
Due to: Microcephaly, congenital	Birth
Due to: 157 d	
Other conditions (Include pregnancy within 3 months of death): Hare-lip + cleft palate; complete	Birth

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

23. Signature: Max Dreitch (M. D. or other) W.D.
Address: Mo. Shea. Bldg. Date signed 11/17/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

No Embalming....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.