

FILED DEC 2 1946

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9789**

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

1. PLACE OF DEATH:  
 (a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
DePaul Hospital 0  
(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)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town Kirkwood  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 110 E. Clinton Pl.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elsie Diemler  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Wm. F. 6. (c) Age of husband or wife if alive 67 years  
 7. Birth date of deceased Feb. 7 1887  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov. day 16th  
 year 1946 hour 6:35 minute \_\_\_\_\_ A. M.  
 21. I hereby certify that I attended the deceased from Nov. 6th 1946 to Nov. 16th 1946,  
 that I last saw her alive on Nov. 15th 1946,  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
 59 9 9 hr. \_\_\_\_\_ min.

Immediate cause of death \_\_\_\_\_  
Trans. Pneumonia Duration today  
 Due to P.  
 Due to 109a

9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife

Other conditions Thrombus in the 5th  
(Include pregnancy within 3 months of death)  
Common place of fibrillation  
 Major findings: none made  
 Of operations \_\_\_\_\_  
 PHYSICIAN

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 12. Name Otto Starck  
 13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
 14. Maiden name Rose Becht  
 15. Birthplace Germany  
(City, town, or county) (State or foreign country)

Of autopsy not made for lack of cadaver  
 Underline the cause to which death should be charged statistically.

16. (a) Informant William F. Diemler  
 (b) Address 110 E. Clinton Pl.  
 17. (a) Burial (b) Date thereof 11 18 46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Valhalla Cemetery

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)

18. (a) Signature of funeral director Kriegshauser Und. Co.  
 (b) Address 4228 So. Kingshighway Bl.  
 19. (a) NOV 17 1946 (b) J. F. Brecht  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature Joseph Davie (M. D. or other) \_\_\_\_\_  
 Address 4401 Tusco Bldg Date signed 11-16-46

FEB 3 1958

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**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..... *Richard W. Stovesand* .....

Licensed Embalmer No. *4007* .....

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.**