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MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **38034**  
Registrar's No. **10062**

FILED DEC 2 1948  
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Johns Hospital **D**  
(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 \_\_\_\_\_ (Specify whether years, months or days)

3: (a) PRINT FULL NAME Edwin C. Dieckberend

3: (b) If veteran, name war No

3: (c) Social Security No. Unknown

4. Sex Male **O** 5. Color or race White

6: (a) Single, widowed, married, divorced Widower

6: (b) Name of husband or wife Unknown

6: (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 19 1900  
(Month) (Day) (Year)

8. AGE: Years 48 Months 5 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation None

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

12. Name Frederich Dieckberend **D**

13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Sophia Rossebrok

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

16: (a) Informant James Dieckberend

(b) Address Okawville, Ill.

17: (a) Removal (b) Date thereof 11-18-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Okawville, Ill.

18: (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19: (a) NOV 20 1948 J. B. Lanter  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Washington **999**

(c) City or town Okawville **16**  
(If outside city or town limits, write "RURAL")

(d) Street No. R.R. **2**  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17  
year 1948 hour 5 minute 00 P.M.

21. I hereby certify that I attended the deceased from 11-16, 1948, to 11-17-48, 1948;  
that I last saw h. alive on 11-17-48, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Perforated gastric ulcer with generalized peritonitis

Duration 3 days

Due to \_\_\_\_\_

Due to 117

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

Major findings:  
Of operations Perforated gastric ulcer

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury O

23. Signature E. H. Buehler (M. D. or other) **2nd**

Address 634 N. Brent Date signed 11/18/48

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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*

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

working under my personal supervision.

Signed

*Elton H. Pennington*

- - Licensed Embalmer No.

*4283*

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.**