

FILED APR 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13498

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 6081 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, St. Charles Township</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, St. Charles Township</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Route #2</u>		d. STREET ADDRESS (If rural, give location) <u>Route #2</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Louise</u> b. (Middle) _____ c. (Last) <u>Diekamp</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 6, 1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 25, 1879</u>
9. AGE (In years) (Last birthday) <u>79</u>		10. MONTHS <u>11</u>	11. DAYS <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>St. Charles County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Hoelscher</u>	
13b. MOTHER'S MAIDEN NAME <u>Wilhelmian Holtgraewe</u>		14. NAME OF HUSBAND OR WIFE <u>Louis Diekamp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Arthur Diekamp</u> ADDRESS <u>Rt. #2, St. Charles, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Anoxemy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hrs</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Generalized Arteriosclerosis</u>	
		DUE TO (c) <u>Essential Hypertension</u>	
II. OTHER SIGNIFICANT CONDITIONS		Arteriosclerotic heart disease <u>4/12X</u>	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>no</u>	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>St. Charles R. 2 (St. Char) Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>no</u>	
22. I hereby certify that I attended the deceased from <u>5/10</u> 19 <u>45</u> to <u>4/6</u> 19 <u>49</u> , that I last saw the deceased alive on <u>4/5</u> 19 <u>49</u> and that death occurred at <u>4:30</u> a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Ralph S. Hayden MDU</u>		23b. ADDRESS <u>St. Charles Mo</u>	23c. DATE SIGNED <u>4/6/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>April 9, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles County, Mo.</u>
DATE REC'D BY LOCAL REG. <u>4/24/49</u>	REGISTRAR'S SIGNATURE <u>Frankie Hanel</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Frankie Hanel</u> ADDRESS <u>St. Charles, Mo</u>	

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

No. 300  
10.48

9200

(Licensed Embalmer's Signature on Reverse Side)

*Mr. Keegan*

RECEIVED  
District Health Officer  
District File Number  
Date Filed APR 28 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed *Charles J. Macke*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *4530*

P. O. Address *St. Charles, 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.