

THE DIVISION OF HEALTH OF MISSOURI  
FILED MAY 20 1949 STANDARD CERTIFICATE OF DEATH

State File No. 17202

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1008 Registrar's No. 4245

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE MISSOURI b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN ST. LOUIS MO |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN ST. LOUIS                             |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>3223 UTAH /                                       |  | d. STREET ADDRESS (If rural, give location)<br>3223 UTAH  |  |

|  |  |   |  |  |                             |                             |
|--|--|---|--|--|-----------------------------|-----------------------------|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) KATHERINE b. (Middle) - c. (Last) DIESEL           |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br>MAY 11 1949 |  |                             |                             |
| 5. SEX<br>FEMALE   | 6. COLOR OR RACE<br>WHITE                    | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>WIDOW | 8. DATE OF BIRTH<br>AUG. 23 1874                     | 9. AGE (In years last birthday)<br>74  | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>WIDOW | 10b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME | 11. BIRTHPLACE (State or foreign country)<br>ILLINOIS           |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |                             |                             |

|   |  |   |
|---|--|---|
| 13a. FATHER'S NAME<br>FREDRICH MILLER                             | 13b. MOTHER'S MAIDEN NAME<br>MARGARETTA BECKER | 14. NAME OF HUSBAND OR WIFE<br>LOUIS DIESEL       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO.                        | 17. INFORMANT'S SIGNATURE OR NAME<br>IRENE DIESEL |
|   |  | ADDRESS<br>3223 UTAH                              |

|   |  |  |   |
|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br>11 mos. |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage   |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Hypertensive heart disease many yrs.<br>DUE TO (c) |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |   |

|  |  |   |
|--|--|---|
| 19a. DATE OF OPERATION                             | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)           | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br>930                              |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br>H.S. 3X   |

22. I hereby certify that I attended the deceased from 8-1-1947, to 5-11-1949, that I last saw the deceased alive on 5-11-1949, and that death occurred at 11:30 m., from the causes and on the date stated above.

|   |                          |   |   |
|---|--------------------------|---|---|
| 23a. SIGNATURE<br>Albert Kaplan M.D.                | (Degree or title)        | 23b. ADDRESS<br>607 N. Grand                        | 23c. DATE SIGNED<br>5-12-49                                     |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL | 24b. DATE<br>MAY 14 1949 | 24c. NAME OF CEMETERY OR CREMATORY<br>MT. EVERGREEN | 24d. LOCATION (City, town, or county) (State)<br>MILLSTADT ILL. |

|   |                                       |  |                        |
|---|---------------------------------------|--|------------------------|
| DATE REC'D BY LOCAL REG.<br>MAY 12 1949 | REGISTRAR'S SIGNATURE<br>J. B. Sauter | 25. FUNERAL DIRECTOR'S SIGNATURE<br>Thomas Kutek | ADDRESS<br>2906 Yarrow |
|---|---------------------------------------|--|------------------------|

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

16

2:00 P.M. 1/30 " St. Louis

**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 \_\_\_\_\_

*Leo J. Bubb*

Signed.....

Student Embalmer

Licensed Embalmer No. 3989

P. O. Address St. Louis, 9

**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.