

No. 300
10.48

FILED SEP 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27770
Registrar's No. 15

BIRTH NO. _____ REG. DIST. NO. 306 PRIMARY REG. DIST. NO. 6048

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1. PLACE OF DEATH a. COUNTY <u>O'Fallon</u> b. CITY (If outside corporate limits, write RURAL and give town) <u>O'Fallon Rural</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>O'Fallon Rural</u> d. STREET ADDRESS _____	
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3. NAME OF DECEASED (Type or Print) a. (First) <u>Jeanette</u> b. (Middle) <u>Marie</u> c. (Last) <u>Dickherber</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 16 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>(Married)</u>	8. DATE OF BIRTH <u>April 23 1949</u>	9. AGE (In years last birthday) <u>1 YR</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 100 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>O'Fallon Mo. Rural</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Dennis Dickherber</u>	13b. MOTHER'S MAIDEN NAME <u>Gentemann</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Dennis Dickherber</u>	ADDRESS <u>O'Fallon Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, atherosclerosis, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>head run over by truck</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>88124</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>O'Fallon St. Charles Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug 16-49 4:45 p.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>accidentally run over by truck</u>
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22. I hereby certify that I attended the deceased from 25th May, 1948, to 16 Aug, 1949, that I last saw the deceased alive on 16 Aug, 1949, and that death occurred at 4:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Lawrence J. Behrman MD</u>	23b. ADDRESS <u>O'Fallon Mo</u>	23c. DATE SIGNED <u>8-27-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 19 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>	24d. LOCATION (City, town, or county) (State) <u>Cottleville Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Aug 27-49</u>	REGISTRAR'S SIGNATURE <u>G. A. Keithey 280</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. A. Keithey</u>	ADDRESS <u>O'Fallon Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
AUG 31 1949
District Health Officer No. 9,
District File Number

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 _____

E. K. Keithly

Signed _____

Student Embalmer

Licensed Embalmer No. _____

872

P. O. Address _____

Fallen 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.