

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35065

State File No.

318

1003

8672

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give town or township) ST LOUIS		c. LENGTH OF STAY (in this place) 5 yr		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		17		
d. FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOME				d. STREET ADDRESS (If rural, give location) 12 4500 WASHINGTON				
3. NAME OF DECEASED (Type or Print) EMILIA A DINKMEIER			a. (First)			b. (Middle)		
c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) OCT. 7 1949					
6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH DEC. 23, 1874		9. AGE (In years) (last birthday) 74		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY.		11. BIRTHPLACE (State or foreign country) ST. CHARLES, MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME BERNHARD KOENIG			13b. MOTHER'S MAIDEN NAME NOT KNOWN			14. NAME OF HUSBAND OR WIFE J. F. DINKMEIER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME THEO B. DINKMEIER, Richmond Heights, Mo				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured aortic aneurysm ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 10/7/49 451X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? 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) 97				
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? HIT				
22. I hereby certify that I attended the deceased from Jan 15, 1949, to Oct. 7, 1949, that I last saw the deceased alive on Oct. 6, 1949, and that death occurred at 12:30P m., from the causes and on the date stated above.								
23a. SIGNATURE H. F. Bereman M.D.			23b. ADDRESS 3220 Washington			23c. DATE SIGNED 10/7/49		
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Oct. 10, 1949		24c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		24d. LOCATION (City, town, or county) (State) ST. CHARLES, MO		
DATE REC'D BY LOCAL REG. OCT 8 1949		REGISTRAR'S SIGNATURE J. B. Lasater			25. FUNERAL DIRECTOR'S SIGNATURE Hockman-Bauer			
					ADDRESS St. Charles Mo			

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

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 Frederic W. Bone

Signed _____
Student Embalmer

Licensed Embalmer No. 4607

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.