

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25687**

No. 300
10-48

JUL 31 1952

BIRTH NO. _____

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **7053**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY 2160	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS /		c. LENGTH OF STAY (In this place) _____	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		d. STREET ADDRESS (If rural, give location) 16 3734 THOLOZAN AVE	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3734 THOLOZAN AVE		d. STREET ADDRESS 16 3734 THOLOZAN AVE	
3. NAME OF DECEASED (Type or Print) BARBARA		a. (First) _____	b. (Middle) _____
c. (Last) DAIGER		4. DATE OF DEATH (Month) (Day) (Year) JULY 20 1952	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH DEC. 2, 1860
9. AGE (In years last birthday) 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	
11. BIRTHPLACE (City and State or Foreign Country) GERMANY		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JOSEPH WIEBER		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE CARL DAIGER (DECEASED)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME WILLIAM DAIGER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		ADDRESS 2107 S BROADWAY	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterial Sclerotic Heart Disease		DUE TO (b) _____		7 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS 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? 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) _____
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? 4200

22. I hereby certify that I attended the deceased from **Nov**, 1951, to **July 20, 1952**, that I last saw the deceased alive on **July 20, 1952**, and that death occurred at **7:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Ralph Thompson M.D.	(Degree or title) M.D.	23b. ADDRESS 3606 Grannis Blvd	23c. DATE SIGNED 7-21-52
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 23 1952	24c. NAME OF CEMETERY OR CREMATORY SS PETER + PAUL CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.

DATE REC'D BY LOCAL REG. JUL 22 1952	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis	ADDRESS 2906 Grannis
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G.P. (Licensed Embalmer's Statement on Reverse Side)

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

D. Rugg Thompson
Bird. Beaver,

1 to 3 PM Monday.

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.

Student
Student Embalmer

Signed Leo J. Cudde
Licensed Embalmer No. 3989
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.