

1-5. No. 300
EV. 10.48

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32864

State File No.

FILED OCT 4 1952

318

1003

Registrar's No.

8824

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. 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 township) OR TOWN ST. LOUIS MO

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2239

d. FULL NAME OF HOSPITAL OR INSTITUTION DEACONESS HOSPITAL

d. STREET ADDRESS (If rural, give location) 23 2721 INDIANA

3. NAME OF DECEASED (Type or Print)
a. (First) LISSETTA b. (Middle) _____ c. (Last) DAEHN

4. DATE OF DEATH (Month) (Day) (Year) SEPT. 20 1952

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH JAN 6 1860

9. AGE (In years last birthday) 92 If under 1 year: Months _____ Days _____ If under 12 hrs: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW

10b. KIND OF BUSINESS OR INDUSTRY AT HOME

11. BIRTHPLACE (City and State or Foreign Country) MISSOURI

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME FRED STULKEN

13b. MOTHER'S MAIDEN NAME UNKNOWN

14. NAME OF HUSBAND OR WIFE LOUIS DAEHN (DEC'D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____

16. SOCIAL SECURITY NO. NONE

17. INFORMANT'S SIGNATURE OR NAME ADDRESS ELLA ROGLIN 2721 INDIANA

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal obstruction

INTERVAL BETWEEN ONSET AND DEATH

*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 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fracture of hip with infection

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 8-80

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 5705

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased _____ from the cause, and, on the date stated above _____

3720 Washington Blvd. 9/27/52

Maurice R. Koch, E.M.

23. REMOVAL (Specify) REMOVAL SEPT. 23 1952 ST. MARTIN CHURCHYARD PLUTMAR, MO

DATE REC'D BY LOCAL REG. SEP 22 1952

REGISTRAR'S SIGNATURE Charles Smith

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Gravois

(Licensed Embalmer's Statement on Reverse Side)

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.

Student

Student Embalmer

Signed

James C. Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Harris

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.