

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33106**  
Registrar's No. **8539**

FILED SEP 24 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jefferson</b>	
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Cedar Hill</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>6 mons</b>		e. STREET ADDRESS (If rural, give location) <b>0500</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>St. Anthony's Hospital</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>ELEANOR</b>		b. (Middle) <b>M.</b>	
		c. (Last) <b>DINK</b>	
		4. DATE OF DEATH (Month) (Day) (Year) <b>8-29-53</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>4-8-1911</b>
9. AGE (In years last birthday) <b>42</b>		10. UNDER 1 YEAR Months	11. UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>High Ridge Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Anton Pfaff</b>	
		13b. MOTHER'S MAIDEN NAME <b>Mary Henning</b>	
		14. NAME OF HUSBAND OR WIFE <b>Walter Dink</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Walter Dink, Cedar Hill, Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Uterus</b>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		<b>Bladder, Rectum &amp; Liver</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUCE TO (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>	
DUCE TO (c) <b>Carcinoma</b>			
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) <b>A</b>		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? <b>174X</b>			
22. I hereby certify that I attended the deceased from <b>April, 1953, to Aug 29, 1953</b> , that I last saw the deceased alive on <b>Aug 29, 1953</b> and that death occurred at <b>4:20 P. M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Albert H. Smith M.D.</b>		23b. ADDRESS <b>3109 S Grand</b>	
23c. DATE SIGNED <b>9/31/53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>8-30-53</b>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>House Springs, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>SEP 2 1953</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Brimmer F.H.</b>		ADDRESS <b>House Springs, Mo.</b>	

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

Utter primary

SEP 24 1958

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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 1366  
P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.