

FILED OCT 26 1954

STANDARD CERTIFICATE OF DEATH

35304

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9425**

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		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		e. STREET ADDRESS (If rural, give location) 5864 Highland Avenue 20690	

3. NAME OF DECEASED (Type or Print)	a. (First) Ida	b. (Middle) Barbara	c. (Last) Diehl	4. DATE OF DEATH (Month) (Day) (Year) 10 - 16 - 1954
--	--------------------------	-------------------------------	---------------------------	---

5. SEX Fem	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4 - 28 - 1884	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
----------------------	----------------------------------	--	--	--	-----------------------------------	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and State or Foreign Country) Freeburg, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	---

13a. FATHER'S NAME John Vogel	13b. MOTHER'S MAIDEN NAME Maria Mueller	14. NAME OF HUSBAND OR WIFE Harry F. Diehl
---	---	--

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.	17. INFORMANT'S SIGNATURE OR NAME Mr. Harry F. Diehl	ADDRESS 5864 Highland Avenue
---	-------------------------	--	--

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		INTERVAL BETWEEN ONSET AND DEATH one day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Ventricular Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Chrome Cardiac Disease		
DUE TO (b)			2 yrs
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 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? 4343
---	--	---

22. I hereby certify that I attended the deceased from Dec 16, 1952, to Oct 16, 1954, that I last saw the deceased alive on Oct 16, 1954, and that death occurred at 12:25 AM from the causes and on the date stated above.

23a. SIGNATURE AM Hand MS	(Degree or title)	23b. ADDRESS 3701 Franklin Ave	23c. DATE SIGNED Oct 18 1954
-------------------------------------	-------------------	--	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/19/54	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
--	------------------------------	---	---

DATE REC'D BY LOCAL REG. OCT 18 1954	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral	ADDRESS 1905 Union Blvd.
--	---	--	------------------------------------

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

Dr. Robt. Nussbaum
~~528 6th St~~
3701 Grandel Square
Sat & Mon
11 to 3:30

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. 423

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.