

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6100**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1640**

1. PLACE OF DEATH a. COUNTY <b>0</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>St Louis</b>	
c. LENGTH OF STAY (in this place) _____		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>2929 2745a Chouteau</b>	

3. NAME OF DECEASED (Type or Print) <b>OTTO DIDION</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>FEBRUARY 19, 1955</b>		
a. (First)		b. (Middle)		c. (Last)	

5. SEX <b>Male 0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married 0</b>	8. DATE OF BIRTH <b>July 27 1871</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Taveran</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Germany</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Jacob Didion</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Unknown</b>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Carl Ruest</b>	ADDRESS <b>3427 Market St</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Heart Failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>GASTRIC ULCER</b>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4200</b>
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22. I hereby certify that I attended the deceased from **1-4-55**, 19\_\_\_\_, to **2-19-55**, 19\_\_\_\_, that I last saw the deceased alive on **2-19-55**, 19\_\_\_\_, and that death occurred at **6:50P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Print or title) <b>Merl J. Schnur M.D.</b>	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>2-21-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	24b. DATE <b>Feb 23 55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Missouri</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>
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DATE REC'D BY LOCAL REG. <b>FEB 21 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Schnur</b>	ADDRESS <b>3125 Lafayette</b>
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M.D. 13 (Licensed Embalmer's Statement on Reverse Side)

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

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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 *Thomas R. Remick*

Licensed Embalmer No. 379

P. O. Address 3125 1/2

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.