

FILED MAR 31 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9504

318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 2294

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's 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 town or township) St. Louis		c. LENGTH OF STAY (in this place) 8 days		c. CITY OR TOWN St. Louis		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 Alexian Brothers Hospital				STREET ADDRESS (If rural, give location) 2205a So. 13th Street 2237			
3. NAME OF DECEASED (Type or Print) Charles		a. (First)		b. (Middle)		c. (Last) Deffaa	
4. DATE OF DEATH March 12, 1955		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH Sept. 21, 1886		9. AGE (In years last birthday) 68		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) Wood Worker		10b. KIND OF BUSINESS OR INDUSTRY Carpentry		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Deffaa		13b. MOTHER'S MAIDEN NAME Mary Schaefer		14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louis Deffaa - 2205a So. 13th St.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac arrhythmia</u>  ANTECEDENT CAUSES DUE TO (b) <u>Fractured Lt. Hip</u> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>O.K. given in hospital 3/14</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19a. DATE OF OPERATION 3-7-55		19b. MAJOR FINDINGS OF OPERATION <u>Fractured Lt. Femur</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) COUNTY STATE St. Louis Mo. Mo.		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 3-2-55 m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall at Home</u>				E9040	
22. I hereby certify that I attended the deceased from <u>3-4</u> , 19 <u>55</u> , to <u>3-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-11</u> , 19 <u>55</u> , and that death occurred at <u>2:30 A.</u> m., from the causes and on the date stated above. <u>21</u>							
23a. SIGNATURE <u>John W. Dierke M.D.</u>				(Degree or title)		23b. ADDRESS <u>3606 Gravois</u>	
23c. DATE SIGNED <u>3-12-55</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE <u>Mar. 14, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>		DATE REC'D BY LOCAL REG. <u>MAR 14 1955</u>		REGISTRAR'S SIGNATURE <u>Charles Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wacker-Keller - 3634 Gravois Ave.</u>	
(Licensed Embalmer's Statement on Reverse Side)							

WRITE PLAINLY—USING UNFAADING 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..... *Robert C Wheeler*

Licensed Embalmer No. *21*

P. O. Address..... *St Louis*

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.