

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 899

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>CLAYTON</u>		c. LENGTH OF STAY (If this place) <u>D.O.A.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS COUNTY HOSP</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. CITY OR TOWN <u>PIPER LAWN</u>		STREET ADDRESS (If rural, give location) <u>6860 STRATFORD</u>	

3. NAME OF DECEASED (Type or Print) <u>ALVIN R. DIECKHAUS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 16 1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT-4-1897</u>		9. AGE (In years last birthday) <u>57</u>
10a. USUAL OCCUPATION (Give kind of work during normal working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS - MO</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>					

13a. FATHER'S NAME <u>VALENTINE DIECKHAUS</u>		13b. MOTHER'S MAIDEN NAME <u>CAROLINE SELDEN</u>		14. NAME OF HUSBAND OR WIFE <u>EMMA DIECKHAUS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>498-07-1981</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Emma Dieckhaus Stratford</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		DUE TO (b) <u>Coronary Sclerosis</u>		<u>Sudden Death</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		<u>Unknown</u>	
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 <u>4201</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 7/1/54, 1954, to 4/16, 1955, that I last saw the deceased alive on 7/6, 1954, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert A. Bauer M.D.</u>		23b. ADDRESS <u>3731 GOODFELLOW</u>		23c. DATE SIGNED <u>4/18/55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>4-19-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>DUTZOW CEMETERY</u>	
24d. LOCATION (City, town, or county) (State) <u>DUTZOW - MO</u>					

DATE REC'D BY LOCAL REG. <u>4/18/55</u>		REGISTRAR'S SIGNATURE <u>Hebeck R. Lonke</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. B. Tanner</u>	
				ADDRESS <u>6101 Bridge</u>	

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 *Elmo R Cadwell*.....

Licensed Embalmer No. *407*

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.