

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23667**
Registrar's No. **6024**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Faith Hospital # 2		e. STREET ADDRESS (If rural, give location) 226 1802 Benton Street	
3. NAME OF DECEASED (Type or Print) a. (First) Cecelia b. (Middle) Marie c. (Last) Dressel		4. DATE OF DEATH (Month) (Day) (Year) July 10th, 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Dec. 3rd, 1889
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	11. BIRTHPLACE (City and State or Foreign Country) Belleville, Illinois
13a. FATHER'S NAME Peter Reeb		13b. MOTHER'S MAIDEN NAME Mary E. Klemke	14. NAME OF HUSBAND OR WIFE Theodore P. Dressel
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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Paul Dressel 1802 Benton Street
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) Meningitis & Pleurisy Both Lungs Dose operating Aspirated Blood from 3 yrs. DUE TO (b) Cholelithiasis, Choleystitis. DUE TO (c) 3 yrs. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 7/14/55		19b. MAJOR FINDINGS OF OPERATION Cholelithiasis, Choleystitis, Cyst Adenoma of Pancreas	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
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) 175 X	
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?			
22. I hereby certify that I attended the deceased from 8/21 , 19 48 , to 7/10/55 , 19 55 , that I last saw the deceased alive on 7/10 , 19 55 , and that death occurred at 11:30pm. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Charles W. Leidner M.D.		23b. ADDRESS 1901 Nolan	
23c. DATE SIGNED 7/12/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 11/55	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.,
DATE REC'D BY LOCAL REG. Jul 12 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leidner Undertaking Co 2223 St. Louis Av.	

(Licensed Embalmer's Statement on Reverse Side)

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 *John S. Penner*.....

Licensed Embalmer No. *419*.....

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.