

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27710**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7095**

1. PLACE OF DEATH a. COUNTY _____		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. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN <b>St. Louis</b>	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>DePaul Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>1062 Wall St.,</b>	<b>2089</b>

3. NAME OF DECEASED (Type or Print) a. (First) <b>THEODORE</b> b. (Middle) <b>P.</b> c. (Last) <b>GIESEKING</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>August 12th, 1955</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 6th, 1902</b>	9. AGE (In years last birthday) <b>53</b>	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) <b>Furniture merchant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>retail furniture</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13a. FATHER'S NAME <b>Henry Giesekeing</b>	13b. MOTHER'S MAIDEN NAME <b>Agnes Heinz</b>	14. NAME OF HUSBAND OR WIFE <b>Esther Giesekeing</b>
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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. <b>498-10-9415</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Esther Giesekeing</b>	ADDRESS <b>1062 Wall 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>36 hr.</b>  <b>5 yrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Myocardial Infarction</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Arterio sclerotic H.D.</b>		
DUE TO (b) _____			
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 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) <b>4200</b>
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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? <b>4200</b>
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22. I hereby certify that I attended the deceased from **Aug 12, 1955**, to **Aug 17, 1955**, that I last saw the deceased alive on **Aug 12, 1955**, and that death occurred at **6:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>H. J. Honick</b> (Degree or title) _____	23b. ADDRESS <b>Mo 48902 River View Blvd</b>	23c. DATE SIGNED <b>8-13-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>8/15/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Bethlehem Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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DATE REC'D BY LOCAL REG. <b>AUG 15 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>DIEDRICH FUNERAL HOME</b>	ADDRESS <b>8319 Hallsferry</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 *Paul A. Wachter*.....

Licensed Embalmer No. *478*.....

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.**