

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42923

FILED DEC 27 1956

318

1003

STATE FILE NUMBER

11242

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5056 Beacon ave		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5056 Beacon AVE		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle F Last Dienstbach			4. DATE OF DEATH Month 12 Day 7 Year 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 14 1882	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pension		10b. KIND OF BUSINESS OR INDUSTRY ####	11. BIRTHPLACE (City and state or country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? Yes USA
13. FATHER'S NAME Charke Dienstbach			14. MOTHER'S MAIDEN NAME Mary Crook		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ## (If yes, give war or dates of service) ##		16. SOCIAL SECURITY NO. 489-05-8542	17. INFORMANT Address Rose M. Dienstbach 5056 Beacon		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO (b) Myocardial infarction DUE TO (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		420.0			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from 11-9-56 to 12-7-56 and last saw ^{her} him alive on 12-7-56 . Death occurred at 12-7-56 5P: m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Paul E. Name D.O.			22b. ADDRESS 6401 W Flourissant		22c. DATE SIGNED 12-8-56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/10/56	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St Louis Mo	
24. FUNERAL DIRECTOR ADDRESS John Stygar & Son 5541 Rieverview Blvd			25. DATE RECD. BY LOCAL REG. DEC 10 1956	26. REGISTRAR'S SIGNATURE Paul Smith MD	

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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..... *J. M. Rister*

Licensed Embalmer No. *39*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.