THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1957

3159

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 538

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, give TOWNSHIP only) OR TOWN ST. LOUIS — Inside Limits Yes X No ☐	c. CITY OR TOWN St.Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 6671a Berthold Ave; — Length of stay in 1b 2 years	d. STREET ADDRESS (If outside, give location) 6671a Berthold Ave. — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print)	First MARGARET	Middle DEITRICH	Last WADE.	4. DATE OF DEATH	Month January Day 16 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	8. DATE OF BIRTH June 25,1878	9. AGE (In years last birthday) 78	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) house wife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Deitrich.	14. MOTHER'S MAIDEN NAME Margaret Hornor.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs.Earl Wimer; 6671a Berthold Ave;			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis

DUE TO (c) Pneumonia Hypostatic

INTERVAL BETWEEN ONSET AND DEATH: 1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4221

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1940, to Jan 16.57 and last saw her/him alive on Jan 15.57

Death occurred at 2:30 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Berthold M.D.	22b. ADDRESS Carleton Bldg	22c. DATE SIGNED 1-17-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan.18,1957	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri.
24. FUNERAL DIRECTOR ADDRESS C.R.Lupton & Sons; 7233 Delmar Blvd.,	25. DATE RECD. BY LOCAL REG. JAN 17 '57	26. REGISTRAR'S SIGNATURE J Earl Smith MD MJB	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually 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 em

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Arnold W. Schoe

Licensed Embalmer No. 38

P. O. Address St. Louis

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