

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 26 1957

State File No. **14617**
Registrar's No. **3634**

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| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | State File No. 14617 | | Registrar's No. 3634 | |
| 1. PLACE OF DEATH a. COUNTY St Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Charles | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis | | c. LENGTH OF STAY (to this place) 3 days | | c. CITY OR TOWN St Charles | | d. 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 Missouri Baptist | | | | e. STREET ADDRESS (If rural, give location) 3010 1026 Jefferson St | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Meta | | b. (Middle) L | | c. (Last) Diehr | | 4. DATE OF DEATH (Month) (Day) (Year) April 15 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH April 3 1967 | | 9. AGE (In years last birthday) 90 | 10. UNDER 1 YEAR Months _____ Days _____ | 11. UNDER 14 MRS. 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 Home | | 11. BIRTHPLACE (City and State or Foreign Country) St Charles Mo | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME Stephen Merten | | | 13b. MOTHER'S MAIDEN NAME _____ | | | 14. NAME OF HUSBAND OR WIFE J. George Diehr | | | |
| 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. _____ | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence Diehr St Charles Mo | | | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONIA, RIGHT LOWER LOBE | | | | | | INTERVAL BETWEEN ONSET AND DEATH QUEEN'S | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. ARTERIOSCLEROTIC HEART DISEASE | | | | | | INDET. | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION 491x | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 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) _____ | | | | | |
| 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? _____ | | | | | |
| 22. I hereby certify that I attended the deceased from 12 APRIL, 1957 to 15 APRIL, 1957 , that I last saw the deceased alive on 15 APRIL, 1957 , and that death occurred at 12:40 P.M. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Robert A. Mayer MD | | | | 23b. ADDRESS 539 N. GRAND, ST LOUIS, 3 MO | | | | 23c. DATE SIGNED 15 APRIL 1957 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE April 17 1957 | | 24c. NAME OF CEMETERY OR CREMATORY St John's Cemetery | | 24d. LOCATION (City, town, or county) (State) St Charles Mo. | | | |
| DATE REC'D BY LOCAL REG. APR 16 57 | | REGISTRAR'S SIGNATURE J. Carl Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William C. Paine St Charles Mo. | | | | | |

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 *Arthur C. [Signature]*.....
Licensed Embalmer No. *314-1*

P. O. Address *St. Charles*.....

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.