

Health, Welfare, Public Service, 300-1-56, All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19524

STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1228

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>ST. LOUIS COUNTY</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		c. CITY OR TOWN <u>OVERLAND 423X</u>		d. STREET ADDRESS (If outside, give location) <u>9444 MIDLAND</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS COUNTY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS COUNTY HOSPITAL</u>		Length of stay in lb <u>2 DAYS</u>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Anna</u>		Middle <u>—</u>		Last <u>Diebold</u>		Month <u>May</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-1880</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (City and state or country) <u>ILL MO, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EARL DIEBOLD</u>			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>bilateral pneumonia —</u>							<u>4 days</u>
DUE TO (b) <u>Cerebral vascular accident oed</u>							<u>3 1/2 wks</u>
DUE TO (c) <u>FX Humerus RT - by 1sty sometime during past week.</u>							<u>week.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatoid arthritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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					
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 <u>May 10, 1957</u> to <u>May 14, 1957</u> and last saw her <u>8:15 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated. <u>May 11, 1957</u> and last saw him <u>alive</u> on <u>May 11, 1957</u>							
22a. SIGNATURE (Degree or title) <u>Jack L. Hagadorn MD</u>				22b. ADDRESS <u>601 S. Brentwood Clayton</u>		22c. DATE SIGNED <u>5-11-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5-15-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LAUREL HILL CEMETERY ST. LOUIS</u>		23d. LOCATION (City, town, or county) (State) <u>MO</u>	
24. FUNERAL DIRECTOR <u>Howard Madel</u>		ADDRESS <u>5930 Southwood</u>		25. DATE RECD. BY LOCAL REG. <u>5-13-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Tomke MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Norman W. Smith*

Licensed Embalmer No.

P. O. Address *St. L.*

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.