

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2829

State File No.

FILED FEB 14 1958

1115

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 2/6/58	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3/ St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 3436 Crittenden st.	
3. NAME OF DECEASED (Type or Print) a. (First) Otto b. (Middle) H. c. (Last) Dierker		4. DATE OF DEATH (Month) (Day) (Year) January 28, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH January 22, 1879
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Herman Dierker	
13b. MOTHER'S MAIDEN NAME Sophie Volquardo		14. NAME OF HUSBAND OR WIFE	
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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lore Buchanan 1926 McCausland Ave
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarct ANTECEDENT CAUSES DUE TO (b) Luetic heart disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General paresis 023 x	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 9-4 , 19 57 , to 1-28 , 19 58 , that I last saw the deceased alive on 1-28 , 19 58 , and that death occurred at 5:50p. m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) L. J. W. Walker M.D.		23b. ADDRESS 5400 Arsenal Street	
23c. DATE SIGNED 1-29-58		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 1-31-1958		24c. NAME OF CEMETERY OR CREMATORY Old St. Marcus Cemetery	
24d. LOCATION (City, town, or county) (State) 6638 Gravois Ave Mo		DATE REC'D BY LOCAL REG. JAN 30, 58	
REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. J. Jegenle 6409 Gravois	

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..... *Jan M. Seymour*

Licensed Embalmer No..... *434*

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.