

Health, Welfare, Public Service

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008334
STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 500 Registrar's No. 547

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| 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. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Ferdinand Twp | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN St. Ferdinand Twp 4000 |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Villa Gesu | | Length of stay in lb 17 yr | d. STREET ADDRESS (If outside, give location) 11755 Riverview |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last SISTER M. GORGONIA DIEBOLD | | | 4. DATE OF DEATH Month Day Year February 21st, 1958 | | |
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|-------------------------|----------------------------------|---|--|--|--------------------------------|--------------------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 17th, 1870 | 9. AGE (In years last birthday) 87 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|-------------------------|----------------------------------|---|--|--|--------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher | 10b. KIND OF BUSINESS OR INDUSTRY religious | 11. BIRTHPLACE (City and state or country) Madison, Wis | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME John Diebold | 13b. MOTHER'S MAIDEN NAME Adelaide Grass | 14. NAME OF HUSBAND OR WIFE none |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Sister M. Bertrude, 11755 Riverview | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 24 hr. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Hypertension w. V. disease | | 10 yrs. |
| | DUE TO (c) 443X | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

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| 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.) |
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| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20e. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|---|--|------------------------------|--------|-------|

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|---|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT <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 |
|---|--|------------------------------|--------|-------|

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| 21. I attended the deceased from Death occurred at 3-15-1949 to 2-21-58 and last saw ^{her} _{him} alive on 2-19-58 3:45 p m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) J M Seydick MD | 22b. ADDRESS 8321 N Broadway | 22c. DATE SIGNED 2-22-58 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 2/26/58 | 23c. NAME OF CEMETERY OR CREMATORY Villa Gesu | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. |
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| 24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, 8399 Hallsferry | ADDRESS | 25. DATE RECD. BY LOCAL REG. 2/21/58 | 26. REGISTRAR'S SIGNATURE Klauber A. Dombke MD |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Elmo A. Pedwell*

Licensed Embalmer No. *4077*

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.