

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035043  
STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2400

S. 300  
1.-57

|   |                           |   |   |   |   |
|---|---------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. CITY <b>St. Louis</b> |   |   |
| b. CITY OR TOWN <b>Rock Hill</b>  |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>Rock Hill 4631</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rock Hill Rest Home 7 Yrs</b>  |                           | Length of stay in 1b  | d. STREET ADDRESS <b>9803 Manchester</b>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VERDA</b> Middle <b>DINKEL</b> Last   |                           |   | 4. DATE OF DEATH <b>9-16-1958</b><br>Month Day Year   |   |   |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>12-9-1882</b>   | 9. AGE (In years) <b>75</b><br>If UNDER 1 YEAR: Months Days<br>If UNDER 24 HRS.: Hours Min. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Housewife</b>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>  | 11. BIRTHPLACE (City and state or country) <b>Largo Twp. Indiana</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |
| 13a. FATHER'S NAME <b>Ezra Randall</b>  |                           | 13b. MOTHER'S MAIDEN NAME <b>Jane Holmes</b>  |   | 14. NAME OF HUSBAND OR WIFE <b>William Dinkel</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <b>No</b>   |                           | 16. SOCIAL SECURITY NO. <b>None</b>   | 17. INFORMANT Address <b>Mrs. R Martin 236 Spring</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic myocarditis</b><br>DUE TO (b) <b>generalized arteriosclerosis</b><br>DUE TO (c) <b>4221</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |                           |   |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>                                       |
| 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<br>Hour Month, Day, Year<br>a.m. p.m.   |                           |   |   |   |   |
| 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 <b>Dec. 1951</b> to <b>9-16-58</b> and last saw her/him alive on <b>9-15-58</b><br>Death occurred at <b>9:35 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                           |   |   |   |   |
| 22a. SIGNATURE <b>H. J. Merlin M.D.</b> (Degree or title)   |                           |   | 22b. ADDRESS <b>3507 Poloma</b>   |   | 22c. DATE SIGNED <b>9-17-58</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |                           | 23b. DATE <b>9-17-1958</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Highland Lawn Cemetery</b>  |   | 23d. LOCATION (City, town, or county) (State) <b>Terre Haute Ind.</b>                 |
| 24. FUNERAL DIRECTOR ADDRESS <b>Parker-Aldrich Webster Groves Mo.</b>   |                           |   | 25. DATE RECD. BY LOCAL REG. <b>9-17-58</b>   | 26. REGISTRAR'S SIGNATURE <b>Herbert R. Danke M.D.</b>                                      |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Leslie Welch* .....

Licensed Embalmer No. *4395*  
P. O. Address *Helena, Idaho*

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.