

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041245

State File No.

FILED NOV 18 1958

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10487**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) St Louis County	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If rural, give location) 6044 Eaton DR, Berkley	

3. NAME OF DECEASED (Type or Print) a. (First) DIANE b. (Middle) Lynn c. (Last) Balch		4. DATE OF DEATH (Month) (Day) (Year) 10 31 1958	
5. SEX FEMALE	6. COLOR OR RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 6-24-57
9. AGE (In years last birthday) 14		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) St Louis Mo
13a. FATHER'S NAME John Balch		13b. MOTHER'S MAIDEN NAME Esther Kramme	14. NAME OF HUSBAND OR WIFE #####
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME E. J Balch ADDRESS 6044 Eaton Drive

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (b) _____		DUE TO (c) _____		3441	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	

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 **June 24, 1957**, to **October 31, 1958**, that I last saw the deceased alive on **October 29, 1958**, and that death occurred at **7:20 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Francis P. Nash (Degree or title) M.D.	23b. ADDRESS 100 N. Euclid	23c. DATE SIGNED 11/1/58
24a. BURIAL, CREMATION, REMOVAL Burial	24b. DATE 11/3/58	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) (State) St Louis Mo		

DATE REC'D BY LOCAL REG. NOV 3 '58	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE John Stygar & Son ADDRESS 5541 Riverview Blv
---	---	---

All diseases in Part I must be causally related.

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, fact should be so stated above.