

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022829

STATE FILE NUMBER

FILED JUL 2 1959

Registration District No.

Primary Registration District No.

Registrar No. 5834

300
-57

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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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1725 Leffingwell		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 1724 Leffingwell Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RONEY Middle DEAN Last DIEL			4. DATE OF DEATH Month June Day 17 Year 1959
5. SEX Male	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 3-17, 1959
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		9b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days Hours Min.
10a. FATHER'S NAME Wilber Dean Diel		10b. MOTHER'S MAIDEN NAME Frances McCain	10c. NAME OF HUSBAND OR WIFE None
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		11. SOCIAL SECURITY NO. None	11. INFORMANT 1724 Leffingwell Wilber Diel, St. Louis, Mo.
12. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			525X
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"/>
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 _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul Simon (Degree of _____) Deputy Coroner 3		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 6/19/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-17-1959	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Centralia, Ill.
24. FUNERAL DIRECTOR Queen-Boggs, Centralia, Ill.		25. DATE RECD. BY LOCAL REG. JUN 19 59	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.

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 Clarence M. Billo

Licensed Embalmer No. 4375
P. O. Address St. Louis, 23 Mo.

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.