

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030342

FILED VS SEP 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7737** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo		Length of stay in 1b	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 DE PAUL HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3525 OSAGE Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BERTHA Middle A. Last DIETRICH			4. DATE OF DEATH Month AUG. Day 19 Year 1959		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH OCT 4 1875	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME FRANK BONDERER		13b. MOTHER'S MAIDEN NAME CATHERINE SIETER		14. NAME OF HUSBAND OR WIFE JOSEPH A. DIETRICH (DECD)	
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. _____	17. INFORMANT Address DOROTHY O. DIETRICH 3525 OSAGE		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 36-4 1/2
IMMEDIATE CAUSE (a)	Lowel obstruction	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Strangulated Richter's Hernia	
DUE TO (b)	561.5	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis Sinit Arteriana		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from Aug 18 1959 to Aug 19 1959 and last saw her Aug 19 1959 her him alive on Aug 19 1959 Death occurred at St. Louis Hospital 3 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Thomas K. Rutes (Degree or title)	22b. ADDRESS 2906 Gracis	22c. DATE SIGNED 8/20/59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
REMOVAL	AUG. 1959	CATHOLIC CEMETERY	CHILICOTHE Mo

24. FUNERAL DIRECTOR Thomas Kutes 2906 Gracis	25. DATE RECD. BY LOCAL REG. AUG 20 59	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Eleanora Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.