

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

59-033732

FILED VS. SEP 29 1959

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

2 8550

UNDECEASED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>22 hrs. 50 min.</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda General Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Parents: 1918 Oregon Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>DIANN</b> Middle <b>LOUISE</b> Last <b>DECKARD</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>10</b> Year <b>1959</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-9-59</b>		9. AGE (last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours <b>22</b> Min. <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Herschel Lee Deckard</b>			13b. MOTHER'S MAIDEN NAME <b>Rosemary Burgess</b>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Mother - 1918 Oregon Ave. St. Louis, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra uterine pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		<b>763.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
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			
21. I attended the deceased from <b>9/9/59 7:00 a.m.</b> to <b>9/10/59</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>9/9/59</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>L. R. Wentzel</b> (Degree or title)				22b. ADDRESS <b>3012 Lafayette</b>				22c. DATE SIGNED <b>9/11/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-30-59</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
24. FUNERAL DIRECTOR <b>Rowland - Aker 4104 Manchester</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>SEP 17 59</b>		26. REGISTRAR'S SIGNATURE <b>Rowland Smith, M.D.</b>			

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.