

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033740

FILED VS OCT 5 1959

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's 2 8747

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hospital		d. STREET ADDRESS (If outside, give location) 4846 S. Broadway	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	CLARA	LOUISE	DILG	9-23-1959			

5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1882	9. AGE (last birthday) 77 Years	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.	Months	Days

13a. FATHER'S NAME Charles H. Thuner	13b. MOTHER'S MAIDEN NAME Clara Neuman	14. NAME OF HUSBAND OR WIFE Theodore E. Dilg
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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. 486-38-7838	17. INFORMANT Theodore E. Dilg	Address 4846 S. Broadway
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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
IMMEDIATE CAUSE (a) Myocarditis Chronic		1 Year
DUE TO (b) Intestinal Neoplasia		3 1/2
DUE TO (c) 594x		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour: _____ a.m. p.m. Month, Day, Year
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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 Jan 1957 to Sept 22 1959 and last saw her alive on Sept 22-1959 Death occurred at 4 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) M. D.	22b. ADDRESS 506 Olive St	22c. DATE SIGNED 9/22/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-25-1959	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery	23d. LOCATION (City, town, or county) 7901 Gravois Ave Mo
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24. FUNERAL DIRECTOR Beauregard Bros.	ADDRESS 6409 Gravois Av	25. DATE RECD. BY LOCAL REG. SEP 23 59	26. REGISTRAR'S SIGNATURE Earl 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Yan M. Sienor

Licensed Embalmer No. 4343

P. O. Address St Louis 70

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.