DURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1959

59-037534

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2-9717

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 Length of stay in 1b	c. CITY OR TOWN St. Louis Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5429 Odell Ave. Inside Limits Yes ☐ No ☐	d. STREET ADDRESS 5429 Odell Ave. (If outside, give location) Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
BLANCHE	H.	DIERKES	Oct.	22	1959

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
Female	White		11-12-1899	59				

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)	12. CITIZEN OF WHAT COUNTRY
Office worker-Doane	Agriculter Service	St. Louis, Mo.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Robert A. Caylor	Lucinda Trueman	Late Alfred Dierkes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	498-36-3599	Blanche Brown	6025 Odell Ave.

MEDICAL CERTIFICATION

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)	Subarachnoid Hemorrhage	1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebrovascular aneurysm	1 day
DUE TO (c)	330x	

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Sept 23, 1957 to Oct 21, 1959 and last saw ~~him~~ her alive on Oct 21, 1959

Death occurred at 12:15 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph Arnold, MD (Degree or title)

22b. ADDRESS 100 N. Euclid

22c. DATE SIGNED 10/23/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Oct. 24, 1959

23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem.

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG. OCT 23 1959

26. REGISTRAR'S SIGNATURE Earl Smith, M.D. E.B.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT 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_____ Signed Edwin A. McDermott

Signature of Student Embalmer

Licensed Embalmer No. 3024

P. O. Address_____

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