OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-041751

FILED VS NOV 19 1959

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210225 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. JOHN'S HOSP. — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY: FRANKLIN
c. CITY OR TOWN: UNION — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 101 HAMBRO — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First MARTHA Middle Last DIEKMANN

4. DATE OF DEATH: Month NOV. Day 5, Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: MAR. 29, 1899
9. AGE (last birthday): 60
IF UNDER 1 YEAR: Months 7 Days 6
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): UNION, MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: EDWARD PISANE
13b. MOTHER'S MAIDEN NAME: IDA KOPMANN
14. NAME OF HUSBAND OR WIFE: JOSEPH DIEKMANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: JOSEPH DIEKMANN Address: UNION, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aneurysm - Basilar Artery - Ruptured
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): c̄ Subarachnoid Hemorrhage
330 x
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

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 10/26/59, to 11/5/59 and last saw her/him alive on 11/4/59
Death occurred at 9 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Francis V. Nash M.D.
22b. ADDRESS: 100 N. Euclid
22c. DATE SIGNED: 11/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: NOV. 9, 1959
23c. NAME OF CEMETERY OR CREMATORY: IMMACULATE CONCEPTION
23d. LOCATION (City, town, or county) (State): UNION MO.

24. FUNERAL DIRECTOR: OLTMANN FUNERAL HOME ADDRESS: UNION, MO.
25. DATE RECD. BY LOCAL REG.: NOV 6 1959
26. REGISTRAR'S SIGNATURE: Earl Smith MD MPC

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MAR 31 1960

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 Ralph Altmann
Signature of Student Embalmer

Licensed Embalmer No. 4808

P. O. Address Union, Mo.

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