

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 3 6 6

FILED VS. JAN 11 1960 317

Registration District No. Primary Registration District No. 500 Registrar's No. 3514

STATE FILE NUMBER

ENDED

| | | | | | | | |
|---|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ladue | | Length of stay in 1b life | | c. CITY OR TOWN Ladue | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION # 12 Lindworth Lane | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) # 12 Lindworth Lane | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Ray M. Middle Dilschneider Last Dilschneider | | | | 4. DATE OF DEATH Month December Day 30th. Year 1959 | | | |
| 5. SEX M. | 6. COLOR OR RACE W. | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 2/21/1902 | 9. AGE (last birthday) 57 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Contractor | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME Henry Dilschneider | | | 13b. MOTHER'S MAIDEN NAME Johanna Kranz | | 14. NAME OF HUSBAND OR WIFE Mrs. Alma T. Dilschneider | | |
| 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. 494-01-8029 | 17. INFORMANT Address Mrs. Alma T. Dilschneider, # 12 Lindworth Lane, Ladue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 minutes | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary sclerosis? | | | | | | ? | |
| DUE TO (c) | | | | | | | |
| 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 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.) | | | | | |
| 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 9-13-46 to present time and last saw him alive on Dec 1 '59 Death occurred at 12-30-59 7:30 p.m. Date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) E. L. McCall M.D. | | | | 22b. ADDRESS Burkwood Mo | | 22c. DATE SIGNED 12-31-59 | |
| 23a. FUNERAL CREMATION Funeral | 23b. DATE 1/2/1960 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri. | | | |
| 24. FUNERAL DIRECTOR Arthur J. Donnelly ADDRESS 3840 Lindell Blvd. | | | | 25. DATE RECD. BY LOCAL REG. DEC 31 1959 | | 26. REGISTRAR'S SIGNATURE John B. Munflay M.D. | |

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 Francis Williams

Licensed Embalmer No. 356

P. O. Address 3840 Lu

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.