

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

**-60-008120**

**FILED VS MAR 7 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **1686** STATE FILE NUMBER

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	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4038 N. 9th.</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HILDA</b> Middle <b>DICKHANS</b> Last			4. DATE OF DEATH Month <b>FEB.</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>FE.</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/13/1886</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo/</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		
13a. FATHER'S NAME <b>(unk) Kraft</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Ruppert</b>		14. NAME OF HUSBAND OR WIFE <b>Harry Dickhans</b>		
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>None</b>	17. INFORMANT Address <b>Mrs. Fredia Frohoff 1920 Sullivan</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>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>	
	DUE TO (c) <b>420.0</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Left Radical Mastectomy Five Years Ago For Adenocarcinoma</b>		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	
---	--	---	--

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 <b>St. Louis</b>	COUNTY	STATE
21. I attended the deceased from <b>2-5-60</b> to <b>2-12-60</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>2-12-60</b> Death occurred at <b>1:55 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <b>John Allen Burrell M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>2-12-60</b>
23a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>	23b. DATE <b>2/15/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	

24. FUNERAL DIRECTOR <b>Robert D. Kinealy 2228 St. Louis Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 13 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed

*Herbert J. Young*

Licensed Embalmer No. *4800*

P. O. Address *Kirkwood*  
*22*

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.