RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-008122

FILED VS FEB 23 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1674 STATE FILE NUMBER

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: 5 days	c. CITY OR TOWN ST. Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN DesLoge — Inside Limits Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) 2308 S. 9TH — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: Rose	Middle:	Last: DieckMANN	4. DATE OF DEATH	Month: Feb Day: 12 Year: 1960
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH: 1-22-1885	9. AGE (last birthday): 75	IF UNDER 1 YEAR: Months / Days — 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): MISSOURI	12. CITIZEN OF WHAT COUNTRY: U. S. A.	
13a. FATHER'S NAME: JOSEPH FOERSTEL	13b. MOTHER'S MAIDEN NAME: THERESA HORCHER		14. NAME OF HUSBAND ~~OR WIFE~~ (Dec'd): ANDREW DIECKMANN		
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: IRMA HUSTEDDE	Address: 2007 a ALLEN	

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)	Coronary thrombosis	5 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	arteriosclerotic heart disease.	2 yrs.
DUE TO (c)	420.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertension

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: St Louis	COUNTY: STATE: Mo

21. I attended the deceased from Oct 9 1959 to Feb 12 1960 and last saw her/him alive on Feb 11 1960 10 P.M.

Death occurred at 12 45 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Max Starkloff MD (Degree or title)	22b. ADDRESS: 512 Dorsey Place	22c. DATE SIGNED: 2/12/60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: Feb 15, 1960	23c. NAME OF CEMETERY OR CREMATORY: S.S. PETER & PAUL CEM	23d. LOCATION (City, town, or county): ST. LOUIS	(State): MO
24. FUNERAL DIRECTOR: Thomas Kutis	ADDRESS: 2906 Gravois	25. DATE RECD. BY LOCAL REG.: FEB 13 1960	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MDB.	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

12-6 [illegible]

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 _____ Signed James C Hill

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 [illegible]

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