

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020828

FILED VS JUN 15 1960

318

1003

5796

STATE FILE NUMBER

| | | | | | | | | |
|---|--|---|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b | | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6105 Adkins</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>6105 Adkins</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Dehler</u> Last | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1960</u> | | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/4/1876</u> | 9. AGE (last birthday) <u>84</u> | 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) <u>retired Custodian</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Belleville, ILL</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Frederick Dehler</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Mary Emig</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Margaret-----</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>487-32-4281</u> | | 17. INFORMANT <u>Margaret Dehler, 6105 Adkins</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> | | | | | | | ? | |
| DUE TO (c) <u>420.0</u> | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myocardial Infarction old</u> | | | | | | 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 <u>8/24/57</u> to <u>6/4/60</u> and last saw him alive on <u>5/31/60</u> | | | | Death occurred at <u>5:30 A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |
| 22a. SIGNATURE <u>August V. Shunkel MD</u> | | | (Degree or title) | | | 22b. ADDRESS <u>4401 Hampton Ave</u> | | 22c. DATE SIGNED <u>6/4/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | | 23b. DATE <u>6/7/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u> | | 23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u> | | (State) | |
| 24. FUNERAL DIRECTOR <u>John L. Ziegenhein & Sons, 7027 Gravois</u> | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>JUN 6 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS

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 E. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Grava

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.