

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</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>5420 FINKMAN</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5420 FINKMAN</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle Last <b>Deeken</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>21</b> Year <b>1960</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-28-1890</b>	9. AGE (last birthday) <b>69</b>	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) <b>PRESSMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>VON HOFFMAN</b>		11. BIRTHPLACE (City and state or country) <b>ST. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>HENRY Deeken</b>			13b. MOTHER'S MAIDEN NAME <b>ELIZABETH KLAUS</b>			14. NAME OF HUSBAND OR WIFE <b>CHARLOTTE Deeken</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>494-10-9441</b>		17. INFORMANT Address <b>CHARLOTTE Deeken 5420 FINKMAN</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>sub Cerebral accident 4/30/59</b> DUE TO (b) <b>Ch. corded on heart 2 3 years</b> DUE TO (c) <b>deser e hypulin</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>422.1</b>						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 SUICIDE HOMICIDE <b>NO</b> <input type="checkbox"/> <input type="checkbox"/> <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 e.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 <b>Mo</b>		STATE		
21. I attended the deceased from <b>4-30-59</b> to <b>11-21-60</b> and last saw her him alive on <b>11-21-60</b> Death occurred at <b>6-00 am</b> on the date stated above, and to the best of my knowledge from the causes stated.								
22a. SIGNATURE (Degree or title) <b>D. C. O'Neil M.D.</b>				22b. ADDRESS <b>1523 S Kingsley</b>		22c. DATE SIGNED <b>11/24/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>Nov 25, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM.</b>		23d. LOCATION (City, town, or county) <b>ST. Louis Co. Mo</b>		(State)	
24. FUNERAL DIRECTOR <b>Thomas Auto 2906 Morris</b>			25. DATE RECD. BY LOCAL REG. <b>NOV 22 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1-3 P. O. Address

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *James C. Dill*

Licensed Embalmer No. 434  
P. O. Address 2906

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