

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 9 days	c. CITY OR TOWN Overland
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarinate Word Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2417-Wallis Ave.

3. NAME OF DECEASED (Type or print) First Joseph Middle Bowles Last Dimmitt			4. DATE OF DEATH Month Dec. Day 16, Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-9-82	9. AGE (last birthday) 78

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	11. BIRTHPLACE (City and state or country) Shelby County, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Walter A. Dimmitt	13b. MOTHER'S MAIDEN NAME Ann E. Vaughn	14. NAME OF HUSBAND OR WIFE Florence L. Dimmitt
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 320-873 CFA	17. INFORMANT Address Florence L. Dimmitt 2417-Wallis Ave
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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 18 mo. 2 yrs.
IMMEDIATE CAUSE (a)	Left Hemiplegia = Ca. of Rt. Lung	
CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.	Arterio Sclerosis	
DUE TO (b)	334xH	
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	
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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
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21. I attended the deceased from **Jan 8, 1958** to **12-16-60** and last saw him alive on **12-15-60**
Death occurred at **6:50A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Herman J. Kroeber M.D.	22b. ADDRESS 9616 Suddland Rd.	22c. DATE SIGNED 12-16-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 12-19-60	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo
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24. FUNERAL DIRECTOR ADDRESS Baumann Bros. Inc. 2504-Woodson Rd-Overland-14-Mo.	25. DATE RECD. BY LOCAL REG. DEC 17 1960	26. REGISTRAR'S SIGNATURE Paul Smith M.D.
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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 David C. Gibb

Licensed Embalmer No. 3457

P. O. Address Carle

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.