

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5387**

STATE FILE NUMBER **61-022474**

Filed JUN 16 1961

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|--|--|---|--|--|--|--|--|--|-------|
| 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 | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3300^e Texas | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3300^e Texas | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First ERNEST Middle L. Last DIETRICH | | | | 4. DATE OF DEATH Month June Day 7 Year 1961 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 12-6-1897 | | 9. AGE (last birthday) 63 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Cutter | | | 10b. KIND OF BUSINESS OR INDUSTRY Int. Shoe Co | | 11. BIRTHPLACE (City and state or country) Hannibal Mo | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Unknown | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service) YES W.W. 2 | | | | 17. INFORMANT ERNEST R DIETRICH Address FAYETTEVILLE ARK. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure, Atherosclerosis. DUE TO (b) 450.0 DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 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 | | | |
| 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 _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Joseph M Querry <i>Deputy Registrar</i> | | | | 22b. ADDRESS 1300 Oak | | | | 22c. DATE SIGNED 6-8-61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE 6/9/61 | | 23c. NAME OF CEMETERY OR CREMATORY GRAND VIEW BURIAL PARK | | 23d. LOCATION (City, town, or county) (State) HANNIBAL MO | | | |
| 24. FUNERAL DIRECTOR JOS. P. FENDLER JR. 7128 MICHIGAN | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. JUN 8 1961 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | |

DATE AMENDED

INSTEAD OF

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. M. Denbley
Licensed Embalmer No. 2653

P. O. Address J. Lee 824

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.