

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035240

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2537 STATE FILE NUMBER

FILED SEP 18 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pasadena Park</u>		Length of stay in 1b <u>16 yrs.</u>	c. CITY OR TOWN <u>Pasadena Park</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7611 Rosedale Dr.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7611 Rosedale</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>S.</u> Last <u>DIERKES</u>	4. DATE OF DEATH Month <u>Sept.</u> Day <u>7,</u> Year <u>1961</u>
---	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>9/3/1902</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>Robert H. Dierkes</u>	13b. MOTHER'S MAIDEN NAME <u>Etta Buchardt</u>	14. NAME OF HUSBAND OR WIFE <u>Mrytle Brockmeier</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>	17. INFORMANT <u>Mrytle Dierkes</u> Address <u>7611 Rosedale</u>
---	---

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)	<u>Ventricular Fibrillation</u>	<u>2 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute myocardial infarction</u>	<u>15 years</u>
	DUE TO (c) <u>Coronary atherosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None Stump Arthritis</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 _____ 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 April 1958 to present and last saw him alive on Sept 6, 1961
Death occurred at 7:30 AM Sept 7, 1961 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William D. Blalock MD</u>	22b. ADDRESS <u>St. Louis Mo 114 N. TAYLOR AVE</u>	22c. DATE SIGNED <u>9/8/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/9/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-8-61</u>	

24. FUNERAL DIRECTOR <u>Cullen Kelly</u> ADDRESS <u>7267 Natural Bridge</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy M.D.</u>
--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE RECEIVED

INSURED BY

ITEM NO. SHOULD READ

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 James A. Lamm

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.