

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

FILED NOV 8 1961

1. PLACE OF DEATH
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **ST. LOUIS, MISSOURI** Length of stay in 1b **5 days**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **BARNES HOSPITAL** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Missouri** b. COUNTY **St. Louis**
 c. CITY OR TOWN **Greendale** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **7545 Marillac Drive** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **HERBERT** Middle **A** Last **DIEKMAN** 4. DATE OF DEATH Month **OCTOBER** Day **24** Year **1961**

5. SEX **male** 6. COLOR OR RACE **white** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **8-25-1894** 9. AGE (last birthday) **67**
 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired City Sales Office** 10b. KIND OF BUSINESS OR INDUSTRY **Swift & Co.** 11. BIRTHPLACE (City and state or country) **St. Charles, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **William Diekman** 13b. MOTHER'S MAIDEN NAME **Alma Strathmann** 14. NAME OF HUSBAND OR WIFE **Gladys Diekman**

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. 17. INFORMANT Address **Mrs. Gladys Diekman, 7545 Marillac Drive**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **GASTROINTESTINAL HEMORRHAGE** INTERVAL BETWEEN ONSET AND DEATH **3 DAYS**
 DUE TO (b) **THROMBOCYTOPENIA** **2 YEARS**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) **MYELOFIBROSIS** **292.3** **2 YEARS**
 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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **AUGUST 28, 1956** to **OCTOBER 24, 1961** and last saw her/him alive on **OCTOBER 24, 1961**
 Death occurred at **12:40 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *[Signature]* **M.D.** 22b. ADDRESS **BARNES HOSPITAL** 22c. DATE SIGNED **10/25/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **burial** 23b. DATE **10-27-61** 23c. NAME OF CEMETERY OR CREMATORY **Friedens Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis, Missouri**

24. FUNERAL DIRECTOR ADDRESS **Math Hermann & Son, Inc. 2161 E. Fair Ave.** 25. DATE RECD. BY LOCAL REG. **OCT 26 1961** 26. REGISTRAR'S SIGNATURE *[Signature]* **M.D.**

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 Clement M. Neary

Licensed Embalmer No. 3732

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.