

MOB MAR 13 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5125
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **City Hospital No. 1** Registered No. **1818** St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
D. 13161

2. PRINT FULL NAME

William Diefenbach Sr.
(a) Residence, No. **1425 Hampton** St. **3** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **married**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/23/39** 19

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF **Pauline Diefenbach**

22. **I HEREBY CERTIFY** That I attended deceased from **12/2/38** **2/23/39**, 19...
him **2/23/39**
I last saw him alive on **2/23/39** 19... Death is said to have occurred on the date stated above, at **2.45 p** m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 10, 1868**

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 **8** **3**

Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. **laborer**
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Hypertrophy of prostate
2 stage prostate
prostatectomy - Bronchitis
Arteriosclerotic heart disease

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

Other contributory causes of importance: **13**

FATHER 13. NAME **Valentine Diefenbach**

Name of operation **Prostatectomy** Date of **1-9-39**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

What test confirmed diagnosis? Was there an autopsy? **no**

MOTHER 15. MAIDEN NAME **Margaret Christ**

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

Accident, suicide, or homicide? Date of injury, 19...

17. INFORMANT (ADDRESS) **Hosp. Info M. Kent**

Where did injury occur? (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL PLACE **New St. Peter & Paul 2-27** 19 **39**

Specify whether injury occurred in industry, in home, or in public place.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Kriegshauser Mortuar**
4228 So. Kingshighway

Manner of injury

FEB 25 1939
20. FILED 19 **J. B. Brubaker** Local Registrar.

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify (Signed) **W. M. Arthur**, M. D.
(Address) **City Hospital No. 1**

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH to be accurately supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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

Registered Apprentice No., working under my personal supervision.

Signed.....

Edwin A. McHenry
3034

Licensed Embalmer No.

P. O. Address

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 this body is not embalmed, above space should be left blank.