No. 2
1-4-41
17-39
X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 2 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29878

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 7217

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Luke's
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution about 2 months (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 5 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5465 Cabanne Ave. 9
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME LOUISE C. DIERSON

3. (b) If veteran, name war Nurse - World War

3. (c) Social Security No.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife ----

6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased November (Month) 26 (Day) 1874 (Year)

8. AGE: Years 66 Months 9 Days 8 If less than one day hr. min.

9. Birthplace Louisville (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation nurse

11. Industry or business school (Hadley)

FATHER
12. Name Arnold Dierson
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace (City, town, or county) unknown (State or foreign country)

16. (a) Informant Miss Engelhart
(b) Address 5465 Cabanne Ave.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 9/6/41 (Month) (Day) (Year)
(c) Place: burial or cremation Louisville, Kentucky

18. (a) Signature of funeral director Alexander & Sons
(b) Address 6175 Delmar Blvd.

19. (a) SEP 5 1941 (Date received local registrar) (b) J. T. Boedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4
year 1941 hour 11 minute 05 p.M.

21. I hereby certify that I attended the deceased from Aug. 30, 1941, to Sept. 4, 1941;
that I last saw her alive on Sept 4, 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Arteriosclerosis	-
Due to: General Arteriosclerosis	-
Due to	
Other conditions: Rt. cerebral hemorrhage 1 mo. before (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Hiram L. Lizzett (M. D. or other) M.D.
Address 3720 Washington Blvd Date signed 9/5/41

(Licensed Embalmer's Statement on Reverse Side)

OCT 2 1941

OCT 15 1941

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 Raymond L. Morris, Registered Apprentice No. 290 working under my personal supervision.

Signed Jos. E. McCulloh

Licensed Embalmer No. 2460

P. O. Address 6175 Delmar

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, fact should be so stated above.

No. 2B
—4-25-41
PI X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 18 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 7217

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Luke's (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Ab. 2 mos. (Specify whether In this community 40 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St. L. (If outside city or town limits, write "RURAL")

(d) Street No. 5465 Cabanne (If rural, give location)

(e) Citizen of foreign country 05 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Louise C. Dierson

3. (b) If veteran, name war Nurse - World War

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 11-26-74 (Month) (Day) (Year)

8. AGE: Years 66 Months 9 Days 8 If less than one day hr. min.

9. Birthplace Louisville Ky (City, town, or county) (State or foreign country)

10. Usual occupation Nurse

11. Industry or business Hadley Ch. School

FATHER
12. Name Arnold Dierson
13. Birthplace Ger. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unk.
15. Birthplace Unk. (City, town, or county) (State or foreign country)

16. (a) Informant Miss Engelhart

(b) Address 5465 Cabanne

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-6-41 (Month) (Day) (Year)

(c) Place: burial or cremation Louisville Ky

18. (a) Signature of funeral director Alexander

(b) Address 6175 Delmar

19. (a) 9-5- (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 4 year 41 hour 11 minute 05 P.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death 83a

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 82a
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. Leggett (M. D. or other)

Address 3720 Wash. Date signed

SUPPLEMENTARY

29878