No. 2
-2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

22447

State File No. 0

FILED JUN 1 1944

Registration District No. 1947

Primary Registration District No. 6076

Registrar's No. 239

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution 1 month 24 days (Specify whether
In this community 5 Year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Hancock 999

(c) City or town Nauvoo 11
(If outside city or town limits, write "RURAL")

(d) Street No. None 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Mr. James B Dierker

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug. (Month) 24 (Day) 1920 (Year)

8. AGE: Years 23 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Lawrence, Nebraska (City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Joseph Dierker
13. Birthplace West Point Iowa (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Eleanor Schroeder
15. Birthplace West Point, Iowa (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dorothy D. Britt

(b) Address 7042 Westmorland Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/3/44 (Month) (Day) (Year)

(c) Place: burial or cremation Fort Madison Iowa

18. (a) Signature of funeral director [signature]

(b) Address 2117 E. Grand Blvd.

19. (a) JUN 5 - 1944 (Date received local registrar) C. G. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3rd year 1944 hour 4:00 minute P. M.

21. I hereby certify that I attended the deceased from April 9, 1944 to June 3, 1944; that I last saw him alive on June 3, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage and Respiratory Paralysis Secondary to

Due to Electric Shock Therapy

Due to Schizophrenia

Other conditions (Include pregnancy within 3 months of death) 193

Major findings:
Of operations 99

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) Accident 096

(b) Date of occurrence 6-3-44

(c) Where did injury occur? St. Vincent's San. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? St. Vincent's San. (Specify type of place)

While at work? no (e) Means of injury Electric shock

23. Signature P. E. Kutrts Clerk (M. D. or other)

Address St. Vincent's Sanitarium Date signed 6/3/44

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(Licensed Embalmer's Statement on Reverse Side)

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 Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. Gra

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.