

No. 2
M-5-43
5-17-39
P I X36671

FILED DEC 12 1945
Registration District No. 318

STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 1003

State File No. _____
Registrar's No. 10306

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

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:
BETHESTA HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 WKS + 2 DAYS
In this community 6-10-16 (Specify whether years, months or days)

3. (a) PRINT FULL NAME DORIS ANN DIESEL
3. (b) If veteran, name 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: JAN 10 1939
(Month) (Day) (Year)

8. AGE: Years 6 Months 10 Days 16
If less than one day _____ hr. _____ min.

9. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

10. Usual occupation SCHOOL GIRL

11. Industry or business _____

12. Name ERWIN E. DIESEL

13. Birthplace MILLSTADT ILL
(City, town, or county) (State or foreign country)

14. Maiden name ANNA BLASE

15. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

16. (a) Informant ERWIN DIESEL

(b) Address 4723 SIGEL AVE

17. (a) BURIAL (b) Date thereof 12-5-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director W. Schumacher

(b) Address 3613 MERAMEC

19. (a) DEC 4 1945 (Registrar's signature) J. F. Bredek
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. LOUIS
(If outside city or town limits, write "RURAL")
(c) City or town ST. LOUIS
(If rural, give location)
(d) Street No. 4723 SIGEL AVE
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month DEC day 3
year 1945 hour 9 minute 15 P. M.
21. I hereby certify that I attended the deceased from 11/26
_____, 19____, to Dec 3, 1945
that I last saw her alive on Dec 3, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pericarditis & Nephrosia
Duration 1 week 2 days

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. Berg (M. D. or other) _____
Address 2253 Nebraska Date signed 12/3/45

12-25-3 N.E.B.

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..... *Francis Williamson*

Licensed Embalmer No. *3565*

P. O. Address..... *St. Louis Mo.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. DecRegistration District No. 318Primary Registration District No. 1003Registrar's No. 10586

1. PLACE OF DEATH:

- (a) County St Louis
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT
FULL NAMEDoris A. Piesel

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
 live _____

7. Birth date of deceased Jan 1 1945
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day _____
 6 _____ min.

9. Birthplace _____
 (City, town, or county) (State or foreign country) Mo

10. Usual occupation

11. Industry or business

12. Name _____
 13. Birthplace _____
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director

(b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec
 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Nephrosia

Due to duration 2 yrs

Other conditions cause: - probably focal infection
 (include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____
 Of operations _____

Of autopsy 90%

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?

While at work? _____ (Specify type of place)
 (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

35186