FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 23 1948

Registration District No. 362

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4531

State File No. 42286

Registrar's No. 61

1. PLACE OF DEATH:
(a) County: Warren
(b) City or town: Warrenton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Katie Jane Memorial Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 week (Specify whether years, months or days)
In this community: 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Charles
(c) City or town: St. Peters,
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Philomena Deister
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: married
6. (b) Name of husband or wife: John Deister
6. (c) Age of husband or wife if alive: 81 years
7. Birth date of deceased: Aug. 16, 1870 (Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 28 If less than one day hr. min.

9. Birthplace: St. Peters, Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
MOTHER FATHER
12. Name: John Zerr
13. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)
14. Maiden name: Gertrude Ernst
15. Birthplace: St. Peters, Mo. (City, town, or county) 0 (State or foreign country)
16. (a) Informant: F.E.Hiler
(b) Address: St. Peters, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-15-48 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Peters, Mo.
18. (a) Signature of funeral director: Leo Stiefvater
(b) Address: St. Peters, Mo.
19. (a) 12/14/48 (Date received local registrar) (b) Mrs Venella Watson (Registrar's signature) 407

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13 year 1948 hour 3 minute 45 A M.
21. I hereby certify that I attended the deceased from 12-7 19 48, to 12-13 19 48, that I last saw h. alive on 12-11 19 48, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia Bilateral Sev	3
Due to: Hypostatic Congestion Cardiac Insufficiency	[illegible]
Due to: Cardiac Arrhythmia	[illegible]
Other conditions: Syph. unknown (Include pregnancy within 3 months of death)	[illegible]

Major findings:
Of operations:
Of autopsy: 4 to 6

PHYSICIAN
Underline the cause of 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: 0
23. Signature: Harold Mehlhop M.D. (M. D. or other)
Address: Wentzville Mo. Date signed 12-14-48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9
District File Number
DEC 23 1948
Date Filed

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 E A Keithly

Licensed Embalmer No. 822

P. O. Address Fallow Me

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.