

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9958

State File No. 3172

318

1003

3172

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3172			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital				d. STREET ADDRESS (If rural, give location) 4236 Osceola					
3. NAME OF DECEASED (Type or Print) Fred W. Dierkes			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH		(Month) (Day) (Year)		Apr. 2, 1949					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 4, 1881		9. AGE (In years, last birthday) 67	
						10. MONTHS 5		11. DAYS 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. 1 yr				10b. KIND OF BUSINESS OR INDUSTRY Motorman		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Fred Dierkes			13b. MOTHER'S MAIDEN NAME Mary Meuser			14. NAME OF HUSBAND OR WIFE Emile Dierkes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) No		17. INFORMANT'S SIGNATURE OR NAME Mrs. Emile Dierkes		ADDRESS 4236 Osceola			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)				DUE TO (b) Acute Regurgitation					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				DUE TO (c) Chronic Schrotic					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				131 Kidney					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:02 P. m., from the causes and on the date stated above.									
22a. SIGNATURE Gabriel E. Taylor Carauer				22b. ADDRESS 1300 Pearl				22c. DATE SIGNED 4-4-49	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-5-49		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL APR 4		REGIS. REC'D		REGISTRAR'S SIGNATURE J. B. Foster		FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home		ADDRESS 6322 S. Grand Blvd.	

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

15

Handwritten mark

Order Office

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed *Leid T. Fossan*

Signed _____
Student Embalmer

Licensed Embalmer No. *4242*

P. O. Address *6322 So Blvd*

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.