

FILED DEC 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40005

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 362 PRIMARY REG. DIST. NO. 4531 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>Warren</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrenton Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Foristell Mo.</u>	
c. LENGTH OF STAY (in this place) <u>14</u> <u>19 days</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Katie Jane Memorial Home</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Arthur</u>		b. (Middle) <u>Earnest</u>	
		c. (Last) <u>Dieckman</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 21 1949</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 30 1870</u>
9. AGE (In years last part day) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer.</u>	11. BIRTHPLACE (State or foreign country) <u>Femme-Osage Mo</u>
		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Earnest Dieckman</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Filling</u>	14. NAME OF HUSBAND OR WIFE <u>Emma Dieckman Foristell</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Emma Dieckman Foristell Mo</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage recurrent</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hypertensive cardio-vascular renal disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>renal disease</u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>331X</u>	
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 <u>Nov 5</u> , 19 <u>49</u> , to <u>Nov 21</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>49</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Arnold J. Holloch M.D.</u> (Degree or title)		23b. ADDRESS <u>Warrenton Mo</u>	23c. DATE SIGNED <u>Nov 22 1949</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov 24 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cappeln Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Cappeln Missouri</u>
DATE REC'D BY LOCAL REG. <u>11-23-49</u>	REGISTRAR'S SIGNATURE <u>Floyd Logan #21</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Nieburg Furn &amp; Und Co Wright City Mo</u>	

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

189  
1  
0

District File Number \_\_\_\_\_  
District Health Officer No. 9,  
RECEIVED NOV 29 1949

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, of \_\_\_\_\_  
Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Julius J. Dieburg  
Licensed Embalmer No. 3366  
P. O. Address Wright City, 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.