

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26316**

FILED AUG 29 1951

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

BIRTH MO. _____		REG. DIST. NO. 53	PRIMARY REG. DIST. NO. 3010	Registrar's No. 295
1. PLACE OF DEATH a. COUNTY Cape Girardeau 0164		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission.) a. STATE Missouri b. COUNTY Cape Girardeau		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN " " "		c. CITY (If outside corporate limits write RURAL and give township) OR TOWN Cape Girardeau 0164		
c. LENGTH OF STAY (If in hospital or institution) 35 yrs		d. STREET ADDRESS (If rural, give location) 1454 Whitener		
d. FULL NAME OF HOSPITAL OR INSTITUTION 1454 WHITENER		d. STREET ADDRESS		
3. NAME OF DECEASED (Type or Print) a. (First) PETER b. (Middle) H c. (Last) DEIMUND		4. DATE OF DEATH (Month) (Day) (Year) Aug 18 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 13-1868	9. AGE (In years) (Last) (Month) (Day) (Year) 82 9 5
10a. USUAL OCCUPATION (Give kind of work done throughout of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Sand Pits	11. BIRTHPLACE (State or foreign country) St Louis Mo O		12. CITIZENSHIP OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Peter Deimund		13b. MOTHER'S MAIDEN NAME Abelona Kaye		14. NAME OF HUSBAND OR WIFE Nelle Deimund
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ✓		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME Mr. Nelle Deimund
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) Chronic Hypertensive Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 yrs 4-5 yrs
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 June 28, 1951 , to Aug. 18, 1951 , that I last saw the deceased alive on Aug 16, 1951 , and that death occurred at 7:00 p.m. , from the causes and on the date stated above.				
23a. SIGNATURE William J. Oehler, M.D.		23b. ADDRESS Cape Girardeau Mo.		23c. DATE SIGNED 8-20-51
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Aug 20-51		24c. NAME OF CEMETERY OR CREMATORY Forest Heights & Johnson Mo.
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE W. Howell		
DATE REC'D BY LOCAL REG. 8-21-1951		REGISTRAR'S SIGNATURE C. C. Summers		ADDRESS Cape Gir. Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

AUG 28 1951

DISTRICT HEALTH OFFICE No. 6

File No.

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.

Student
Student Embalmer

Signed *J. H. Howell*

Licensed Embalmer No. *23970*

P. O. Address *Capl. Bureau*

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.