

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43381**
Registrar's No. **11535**

FILED JAN 10 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) ST. LOUIS	c. LENGTH OF STAY (in this place) 15 HRS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. ANTHONY'S HOSP.		d. STREET ADDRESS (If rural, give location) 23 2628 S JEFFERSON	

3. NAME OF DECEASED (Type or Print) a. (First) DOROTHY b. (Middle) L. c. (Last) DISCHBEIN			4. DATE OF DEATH (Month) (Day) (Year) DEC 14 1952		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV 18 1924	9. AGE (In years last birthday) 28	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLER		10b. KIND OF BUSINESS OR INDUSTRY JOY MFG. CO.		11. BIRTHPLACE (City and State or Foreign Country) MISSOURI	
13a. FATHER'S NAME CHARLES HIESTAND			13b. MOTHER'S MAIDEN NAME LILLY CARL		14. NAME OF HUSBAND OR WIFE ROBERT DISCHBEIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS ROBERT DISCHBEIN 2628 S. JEFFERSON		
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Air Emboli -		INTERVAL BETWEEN ONSET AND DEATH 10 minutes
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pregnancy Full term		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (a.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? 6786

22. I hereby certify that I attended the deceased from **July 17, 1951** to **Nov. 14, 1952**, that I last saw the deceased alive on **Nov. 14, 1952** and that death occurred at **12:10 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Dr. Simpson</i>	(Degree or title)	23b. ADDRESS 3739 GRAVOIS	23c. DATE SIGNED 12-15-52
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE DEC 17 1952	24c. NAME OF CEMETERY OR CREMATORY NATIONAL CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.

DATE REC'D BY LOCAL REG. DEC 15 1952	REGISTRAR'S SIGNATURE <i>Charles W. Thomas</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Thomas Rutes 2906 Gravois</i>
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(Licensed Embalmer's Statement on Reverse Side)

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

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 George E. Will

Licensed Embalmer No. 4347

P. O. Address 2906 Ravin

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.