

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 18 1953

State File No. _____

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

Registrar's No. **2163**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) University City	
c. LENGTH OF STAY (In this place) 6 days		d. STREET ADDRESS (If rural, give location) 6557 University Drive	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not hospitalized or in institution, give street address or location) 4373 West Pine Blvd. Stone Nursing Home			
3. NAME OF DECEASED (Type or Print) a. (First) Emily		b. (Middle)	c. (Last) Diehl
4. DATE OF DEATH (Month) (Day) (Year) Feb. 24, 1953			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W.	8. DATE OF BIRTH Aug. 29, 1873
9. AGE (In years last birthday) 79		10. UNDER 1 YEAR 5	11. UNDER 10 HRS. 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk—Ladies ready to Wear		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME James Madigan	
13b. MOTHER'S MAIDEN NAME Mary Donahue		14. NAME OF HUSBAND OR WIFE Michael Diehl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. not known	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. P. J. Moran, 6605 Kingsbury Blvd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Hemorrhage	
ANTECEDENT CAUSES		DUE TO (b) Coronary Artery disease and Myocardial damage.	
DUE TO (c) Arteriosclerosis		II. OTHER SIGNIFICANT CONDITIONS infirmitates of eye	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	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 4201
22. I hereby certify that I attended the deceased from July 12, 1948 , to Feb 24, 1953 that I last saw the deceased alive on Feb 14, 1953 , and that death occurred at 1 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Leo P. Schaefer, M.D.		23b. ADDRESS 448 1/2 Belmont Blvd. University City, Mo.	23c. DATE SIGNED Feb 25, 1953
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb. 26, 1953	24c. NAME OF CEMETERY OR CREMATORY Rolla Cemetery
24d. LOCATION (City, town, or county) (State) Rolla, Mo.		DATE REC'D BY LOCAL REG. FEB 25 1953	
REGISTRAR'S SIGNATURE J. Carl Smith		FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	
ADDRESS 3840 Lindell Blvd.			

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Wm S. Saper*

Licensed Embalmer No. 4699

P. O. Address St Charles, 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.