

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 1 1954

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 43 YRS.		e. STREET ADDRESS (If rural, give location) 844 S. NEWTON	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.			

3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) _____ c. (Last) DIETERMAN			4. DATE OF DEATH (Month) (Day) (Year) JAN. 24 1954		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 25 1890	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Days _____ IF UNDER 1 HOUR _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and State or Foreign Country) COUNCIL BLUFFS, IOWA		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME FRANK HANSON	13b. MOTHER'S MAIDEN NAME BRIDGET McCAFFERTY	14. NAME OF HUSBAND OR WIFE JOSEPH W. DIETERMAN
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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. NO	17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOSEPH W. DIETERMAN, SPRINGFIELD, MO.
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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) Carcinosis of Liver		DUE TO (b) _____		4 yrs.
*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) _____		
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"/>
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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) 5810
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 1-10, 1951, to 1-24, 1954, that I last saw the deceased alive on 1-24, 1954, and that death occurred at 5P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) S.P.D. Duncan M.D.	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 1-26-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1/27/54	24c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	24d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
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DATE REC'D BY LOCAL REG. 1-27-54	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. H. LOHMEYER SPRINGFIELD, MO.
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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.....
Signature of Student Embalmer

Signed *Lucian T. Swadlow*.....

Licensed Embalmer No...48...

P. O. Address *Spring*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.