

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6094**
Registrar's No. **1226**

BIRTH NO. **FILED MAR 4 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 Missouri b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Festus	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If rural, give location) 301 Walnut	
3. NAME OF DECEASED (Type or Print) a. (First) Ella b. (Middle) Katherine c. (Last) Dinger		4. DATE OF DEATH Feb. 6, 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 16, 1888 9. AGE (In years last birthday) 65/7/20 10. MONTHS 65 11. DAYS 7 12. HOURS 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Charles, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Rev. C. C. E. Brandt		13b. MOTHER'S MAIDEN NAME Unknown deKoff	
14. NAME OF HUSBAND OR WIFE Jacob F. Dinger		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 Ralph E. Dinger ADDRESS Louis 330 N. Newstead St. I.	
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) Carcinoma of Liver ANTECEDENT CAUSES Cholelithiasis DUE TO (b) Cholelithiasis 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 12/9/53		19b. MAJOR FINDINGS OF OPERATION Cholelithiasis	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT (Specify) SUICIDE	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 1561		22. I hereby certify that I attended the deceased from 11-19-53, 19 , to 2-6-54, 19 ; that I last saw the deceased alive on 2-16-54, 19 , and that death occurred at 3:03 a. m. , from the causes and on the date stated above.	
23a. SIGNATURE Leo H. Hansen (Degree or title) M.D.		23b. ADDRESS 3701 Grandbl St	
23c. DATE SIGNED 2/8/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 2/9/54		24c. NAME OF CEMETERY OR CREMATORY Roselawn	
24d. LOCATION (City, town, or county) (State) Festus, Mo		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith ADDRESS Festus, Mo.	
DATE REC'D BY LOCAL REG. FEB 8 1954		REGISTRAR'S SIGNATURE Carl Smith	

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

Robert M. Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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.