

THE DIVISION OF HEALTH OF MISSOURI

FILED SEP 29 1955

STANDARD CERTIFICATE OF DEATH

State File No. **30759**
Registrar's No. **8184**

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
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) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital				e. STREET ADDRESS (If rural, give location) 23 2753 Armand Pl.,					
3. NAME OF DECEASED (Type or Print). a. (First) Katherine			b. (Middle) _____		c. (Last) Dinga		4. DATE OF DEATH (Month) (Day) (Year) 9 16 '55		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10/6/'91		9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Martin Frano			13b. MOTHER'S MAIDEN NAME Belko		14. NAME OF HUSBAND/OR WIFE John Dinga				
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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John Dinga-2753 Armand Pl.,					
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) BRONCHO. PNEUMONIA ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) PARALYSIS AGITANS DUE TO (c) GENERALIZED ARTERIO SCLEROSIS II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 Wks 2 YEARS 5 YEARS	
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) 350X					
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 OCT 10, 1954 , to SEPT 10, 1955 , that I last saw the deceased alive on SEPT 16, 1955 , and that death occurred at 10:20 m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) George A. Damon M.D.				23b. ADDRESS 5203 Chippewa		23c. DATE SIGNED 9/18/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9/19/'55		24c. NAME OF CEMETERY OR CREMATORY Our Redeemer Cem.,		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. SEP 19 1955		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home-1926 Allen Ave					

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 *Reinhold K. Lohman*

Licensed Embalmer No. *339*

P. O. Address *St. Louis*

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.