FILED FEB 26 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6126

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1393

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 5641a Finkman Ave. — Length of stay in 1b 01

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 5641a Finkman Ave. — Reside on Farm Yes ☐ No ☐ 20290

3. NAME OF DECEASED (Type or print) First HILDA Middle Last DIETRICH

4. DATE OF DEATH Month Feb. Day 8 Year 1957

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH May 1, 1875

9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Mascoutah, Ill.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Emil Scheitlin

14. MOTHER'S MAIDEN NAME Wilhelmina Seibert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Clarence Dietrich 5641a Finkman Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute. — INTERVAL BETWEEN ONSET AND DEATH 36 hours.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-6-57, to 2-8-57 and last saw her/him alive on 2-8-57. Death occurred at 10:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. M. Komanetsky M. D. 0

22b. ADDRESS 6402a Morganford Rd St. Louis 16 Mo.

22c. DATE SIGNED 2-11-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE Feb. 12, 1957

23c. NAME OF CEMETERY OR CREMATORY St. Paul Churchyard

23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR Kriegshauser — ADDRESS 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG. FEB 11 '57

26. REGISTRAR'S SIGNATURE J. Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by .....; Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed William B. White.....

Licensed Embalmer No. [illegible]

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.