

FILED MAR 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHSTATE FILE NO. 10156
2136

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>INSTITUTION DePaul Hospital</u>			Length of stay in lb <u>6wks</u>		d. STREET ADDRESS (If outside, give location) <u>4475 West Pine</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Adele</u> Middle <u>NMI</u> Last <u>Dieckriede</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1866</u>		9. AGE (In years last birthday) <u>90yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Bernard Dieckriede</u>				14. MOTHER'S MAIDEN NAME <u>Emma Mincke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Edwin Dieckriede 7514 Byron Pl.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral hemorrhage, thrombosis</u> DUE TO (c) <u>331+</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks.</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>January 13, 1957</u> to <u>March 3, 1957</u> and last saw <u>her</u> alive on <u>March 3, 1957</u> . Death occurred at <u>March 3, 1957 9:45 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John T. Loutan, M.D.</u> (Degree or title)				22b. ADDRESS <u>634 N. Grand Blvd.</u>		22c. DATE SIGNED <u>3-4-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 6, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis</u>		(State) <u>Mo.</u>
24. FUNERAL DIRECTOR <u>Gleason & Sons, 6175 Delmar</u>			25. DATE RECD. BY LOCAL REG. <u>MAR 4 '57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

S. 300
1-56

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. securing the medical certification in the specific manner required by 193.140 makes 194.

(Licensed Embalmer's Statement on Reverse Side)

Dr. Althaus
Lister

F07-1953

Dr. John T. Cantor

303 3076
716 716
737

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 *Joseph M. Cullon*

Licensed Embalmer No. *246*

P. O. Address *6175 8th*

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.