

FILED FEB 18 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007137
State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **965**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS	c. LENGTH OF STAY (in this place) 4 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) LADUE	443/0
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		d. STREET ADDRESS (If rural, give location) 601 S. PRICE ROAD	

3. NAME OF DECEASED (Type or Print) a. (First) ADOLPH b. (Middle) M. c. (Last) DIEZ			4. DATE OF DEATH (Month) (Day) (Year) JANUARY 25, 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH NOVEMBER 22, 1865		9. AGE (In years last birthday) 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY LEATHER	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME DIEZ	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE OTHELIA DIEZ, DECEASED
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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)	16. SOCIAL SECURITY NO. 430-24-4457	17. INFORMANT'S SIGNATURE OR NAME MRS. S. ALBERT HANSEN, 601 S. PRICE RD	ADDRESS
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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) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Nephritis DUE TO (c) Arteriosclerosis		
	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? 2 YES <input type="checkbox"/> NO <input checked="" 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)
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 **Sept 2, 1957**, to **Jan 25, 1958**, that I last saw the deceased alive on **1/25, 1958** and that death occurred at **2:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Otto C. Hansen MD (Degree or title)	23b. ADDRESS 3012 Lafayette	23c. DATE SIGNED 1/27/58
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-28-58	24c. NAME OF CEMETERY OR CREMATORY BELLEFONTAINE CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI
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DATE REC'D BY LOCAL REG. JAN 27 '58	REGISTRAR'S SIGNATURE Paul Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE STOCK MORTUARY, 889 S. BRANTWOOD	ADDRESS
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WRITE PLAINLY—USING UNFAADING 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 _____
Student Embalmer

Signed

Paul A. Wacker

Licensed Embalmer No. 4787

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.